Royal Shrewsbury Hospital

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Ratings

Summary of findings

Overall summary of services at Royal Shrewsbury Hospital

Inadequate

Our rating of services stayed the same. We rated them as inadequate because:

We carried out an unannounced focused inspection of the emergency department at Royal Shrewsbury Hospital on 17 February 2020, 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 emergency department. We also undertook an unannounced inspection of Princess Royal Hospital, Telford on 18 February 2020 which has been reported separately.

During this inspection we inspected using our focused inspection methodology. We did not cover all key lines of enquiry however we have rated this service in accordance with our enforcement policy.

This was a focused inspection to review concerns relating to the emergency department. It took place between 12pm and 8pm on Monday 17 February 2020.

We found:

The design, maintenance and use of facilities, premises and equipment did not keep people safe.

Staff did not consistently apply control measures to protect patients, themselves and others from infection risks.

Staff did not always promptly identify and quickly act upon patients at risk of deterioration. Staff did not always complete risk assessments for each patient in a prompt manner. They did not always act to remove or minimise risks or update the assessments when risks changed.

The service did not have enough permanent nursing staff with the right qualifications, skills, training and experience to consistently keep patients safe from avoidable harm and to provide the right care and treatment. However, staffing gaps were filled with temporary bank and agency staff.

The service did not have enough permanent medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service was not designed or delivered in a manner that respected patients' privacy and dignity. Staff did not always have the time to interact with people in a meaningful way.

People could not always access the service when they needed to, and they did not always receive the right care promptly. Waiting times from arrival to treatment and arrangements to admit, treat and discharge patients fell well below national standards.

Leaders did not have the skills and abilities to run the service in a safe and effective manner. Leaders did not understand and manage the priorities and issues the service faced. Senior leaders were not always visible and approachable in the service for patients and staff.

The service did not have a clear vision for what it wanted to achieve or an effective strategy to turn it into action. However, senior leaders engaged with stakeholders regarding the planning of future ED services.

Leaders in the ED did not operate effective governance processes throughout the service. The service did not always identify, escalate and mitigate relevant risks and issues.

Staff did not always feel respected, supported and valued.

Summary of findings

Importantly, the trust must:

Action the hospital MUST take to improve

Ensure that staff comply with nationally recognised infection control standards.

Ensure patients are risk assessed in a timely way and that risks associated with the delivery of health care is mitigated as far as is reasonably practicable.

Ensure there are enough numbers of staff across all professions and grades with the right skills, competency and experience, are always employed and deployed . This includes but is not limited to ensuring there are enough numbers of competent staff to care for infants and children.

Ensure staff comply with local early warning systems to ensure patients at risk of deterioration are recognised and treated within defined time scales.

Ensure patients can access care and treatment in a timely way.

Ensure there are robust governance processes in place which assist in evaluating and improving the quality of care provided to patients accessing the emergency care pathway.

Ensure patients requiring time critical medicines are clinically assessed and such medicines are prescribed and administered in a timely way.

Ensure patients are treated with dignity and their privacy is always protected .

Ensure patients are managed in an environment which is fit for purpose.

Professor Edward Baker

Chief Inspector of Hospitals

Urgent and emergency services

Inadequate

Summary of this service

Our overall rating of this service stayed the same. We rated it as inadequate because:

We carried out an unannounced focused inspection of the emergency department at Royal Shrewsbury Hospital 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 emergency department. During this inspection we inspected using our focused inspection methodology. As a result of this inspection, we took the decision to rate the service based on us issuing requirement notices. We rated the safe, caring, responsive and well-led domains as inadequate. The service was therefore rated inadequate overall.

We previously inspected the emergency department at Royal Shrewsbury Hospital in November 2019. We rated it as inadequate overall. Following this inspection, we initially considered using our urgent enforcement powers due to significant concerns we had over the health and safety of patients in the department. In accordance with guidance issued by the National Quality Board (NQB) and in response to our concerns, system wide risk summits were held on 13 December 2019, 21 January 2020 and 25 February 2020. Risk summits provide a mechanism for key stakeholders involved in the system-wide delivery of health and/or social care to come together to share and review information when a serious concern about the quality of care has been raised. Risk summits enable those organisations to facilitate rapid, collective judgements about the quality of a service and to agree actions needed because of the risks identified.

The Shrewsbury and Telford Hospitals NHS Trust is the main provider of district general hospital services for nearly half a million people in Shropshire, Telford and Wrekin and mid Wales. The trust has two main hospital sites: Royal Shrewsbury Hospital and Princess Royal Hospital in Telford.

- The trust has 721 acute beds (+9% from June 18), 22 critical care beds (+5% from June 18) and 37 maternity beds (0% change).
- From March 2018 to February 2019, there were 123,851 inpatient admissions (+8% compared to previous year). 9,068 of these were children, approximately 8.6% of all admissions.
- There were 718,882 outpatient attendances (+12% from previous year).
- There were 121,442 accident and emergency department attendances (+9% from previous year).
- The trust employs 5,108 WTE staff.

The emergency department (ED) at Royal Shrewsbury Hospital RSH) provides services 24-hours per day, seven days per week service.

The ED at RSH consists of:

- A booking in and streaming area. Streaming at this ED involved identifying if a patient required assessment and treatment within the ED or within the urgent care centre which was operated by another provider on site.
- A main waiting area.
- A children's waiting area.
- One triage room (a second triage room was being created at the time of the inspection)

Urgent and emergency services

- A four bedded resuscitation bay.
- 12 majors' cubicles. Patients who were referred to this area of care could be unstable in their presentation, unable to mobilise and require immediate treatment or medication
- A four bed 'pit stop'. This is where most patients who attended the department by ambulance received their initial assessment.
- A clinical decision unit (CDU) that could accommodate up to 10 patients. The CDU was a short stay inpatient area for ED patients only who require on-going observations, treatments and reviews where the main outcome is discharge from hospital within a 36-hour period.
- Three minors' cubicles providing care to patients who presented with minor injuries.
- A fit to sit area that could accommodate up to four patients who were well enough to sit and await discharge or further assessment.
- A relatives' room.
- Two rooms that could be specifically utilised for the assessment and treatment of children.

There was also an urgent care centre located adjacent to the main waiting area. This was managed separately by another provider and therefore did not form part of this inspection.

During the inspection, we visited the emergency department only. We spoke with 19 staff including registered nurses, health care assistants, reception staff, medical staff, and senior managers. We spoke with eight patients and three relatives. During our inspection, we reviewed 59 sets of patient records.

Is the service safe?

Inadequate

Our rating of safe stayed the same. We rated it as inadequate because:

The design, maintenance and use of facilities, premises and equipment did not keep people safe.

- The design of the environment did not follow national guidance. For example, national guidance aimed at providing a safe environment for children presenting at an ED was not being followed. The environment standards set out in the June 2018 Royal College of Paediatrics and Child Health (RCPCH) guidance, Facing the Future: Standards for children in emergency care settings was also not being followed. For example, this guidance states that children's areas should be monitored securely and zoned off with access control to protect children from harm, including the ability to contain someone who may want to leave the department against clinical advice. The children's waiting area was not secure or zoned off as required. It was located off one of the hospital's main corridors and was also very accessible from the nearby main ED waiting area and the nearby fracture clinic. During the inspection, we spent periods of time observing both the children's waiting area and the main waiting area. There was a consensus among nursing staff that children were not routinely directed to the children's waiting area due to it having very poor line of sight away from clinical staff. We observed one occasion when four children were present in the main waiting room which was occupied with adult patients; one of whom was a detained patient who was handcuffed to prison security staff.
- National guidance relating to provision of a safe environment for patient's presenting at the ED with acute mental health concerns was not followed. The July 2017 Royal College of Emergency Medicine, Best Practice Guideline: Emergency Department Care recommends that ED's provide a dedicated psychiatric assessment room that conforms

to Psychiatric Liaison Accreditation Network (PLAN) standards. At the time of our inspection, a new room had been commissioned however the room did not meet national standards. Although there were two doors which had been fitted with anti-ligature handles, the door closes were not of an appropriate design. Further, the door frames had not been fitted with anti-barricade mechanisms. Light weight furniture including a general waste bin was in the room which afforded patients items which could be thrown or use as a means of barricading internally opening doors. Air ventilation shafts were present in the room, suggestive of pipework being present above the false, non-secured ceiling tiles; such pipework and other ancillary equipment posed ligature risks. We raised this with the director of nursing who reported the room had been reviewed by members from the mental health service who confirmed the room was fit for purpose. The director of nursing reported they would act to resolve the issues identified at the time of the inspection.

- The ED premises were outdated and did not meet the April 2013 Health Building Note 15-01: Accident & emergency departments Planning and design guidance as the ED's building date preceded this guidance.
- The ED environment was not secure and did not protect patients from being accessed by people who may pose a threat to their health and wellbeing. Equipment was also not protected from being accessed and tampered with or stolen. Throughout our inspection, all areas of the ED were easily accessible to all staff, patients and visitors. People were able to freely access areas including the resuscitation bay where seriously ill patients were located.
- Because of bed capacity challenges at the trust, patients were regularly and routinely cared for in the ED corridors. This meant corridors were cluttered and left reduced space for staff and patient movement in the event of an emergency. During the inspection, 16 patients were being cared for along corridors. Patients did not always have access to call bells to alert staff in the event they required assistance. We spoke with four patients who were being cared for along the corridor. They reported they relied on waiting for a member of staff to pass by or had to ask a relative or call out for help. This meant there was an inherent risk in that those patients who may feel acutely unwell or who were at risk of rapidly deteriorate, may not be able to call for immediate help.
- The CDU had previously been established by the trust on the advice of national partners including the Emergency Care Intensive Support Team (ECIST) in response to an increasing demand and to manage severe departmental overcrowding during the winter of 2018/19. However, the CDU did not meet any national service specification and was not fit for purpose. This was recognised by the acting clinical lead as an area of concern. They acknowledged there were benefits to having the area which could be redeveloped as a frailty unit, however this had not progressed. Staff reported there was a general acceptance of the poor environment which posed risks to patients and staff.
- We had previously reported patients in the clinical decision unit had limited access to call bells. Patients who were located outside of a trolley/bed space in chairs did not have access to call bells and we saw that one vulnerable patient who did occupy a trolley/bed had their call bell within reach however the cable had been disconnected from the wall. This meant the patient was unable to call for help despite being in a vulnerable state and being nursed behind closed curtains.
- The clinical decision unit was historically two separate head and neck operating theatres. The two areas were split to provide single sex accommodation. Both rooms were divided by disposable curtains, and staff reported three patients could be managed in each area. During the inspection, five patients were allocated across the two rooms. Each bed space was extremely small. There were no toilet or shower facilities and hand washing facilities were limited to existing surgical hand scrub sinks. There was no space for nursing staff to store or prepare medication. We noted one patient's medicines were stored on the desk located between the two CDU rooms, allowing easy access from members of the public to remove them. Nursing staff were required to leave the CDU area in the event they were required to prepare medicines, therefore leaving the area unsupervised for periods of time, as was observed during the inspection.

- There was no fixed piping to provide oxygen or suction. There were two portable suction units available in the clinical decision unit. Nursing staff reported oxygen could be provided via oxygen cylinders which were installed on the trolleys used in the department. However, we noted one patient was being nursed on a bed which did not have space for a portable oxygen cylinder. Nursing staff working in the CDU confirmed that whilst there was no resuscitation trolley available in the CDU there was one located directly outside in the main corridor; this trolley had been regularly checked and was equipped with a portable automated electronic defibrillator, airway adjuncts and venous access equipment, as well as medicines used as part of advanced life support management. A foundation year doctor who was present in the CDU was not aware of the location of the nearest resuscitation trolley. We asked nursing staff covering the area the location of the nearest; they were able to direct us to the trolley located in the corridor located adjacent to the majors area.
- Staff had access to sepsis trolleys. These are ready made boxes which include sepsis step by step guidance and all the items required to deal with a suspected sepsis patient quickly, for example fluids. We randomly sampled equipment on the trolley and found all items to be in date.

Cleanliness, infection control and hygiene

Staff did not consistently apply control measures to protect patients, themselves and others from infection risks

- During the inspection, five patients in the ED were source isolated due to conditions including norovirus and Clostridium difficile. These patients were nursed in side rooms to reduce the spread of infections; this was consistent with best practice standards. However, there were no signs on the doors to alert staff or visitors to the infection control precautions which should be adopted to safeguard individuals and other patients. We observed multiple episodes of care whereby staff did not routinely adopt personal protective equipment, nor were hands decontaminated before and after contact with these isolated patients. This posed a risk to other patients, staff and visitors.
- We observed a further episode of care during which a nurse inserted a peripheral venous cannula in a patient without adopting any form of aseptic non-touch-technique. This was contrary to best practice standards.
- There were multiple occasions when staff were observed not washing their hands either before or after having had physical contact with patients or soiled materials.
- There were not enough handwash basins across the departments to enable staff easy and timely access to decontaminate their hands between patient contacts. Health building note 00-10 requires all clinical wash-hand basins be installed in all clinical areas. The sink and taps present in the pit stop area did not meet these requirements.

Assessing and responding to patient risk

Staff did not always promptly identify and quickly act upon patients at risk of deterioration. Staff did not always complete risk assessments for each patient in a prompt manner. They did not always act to remove or minimise risks or update the assessments when risks changed.

- National guidance relating to the initial assessment of patients who presented at the ED was not always followed. The February 2017 Royal College of Emergency Medicine Initial Assessment of Emergency Department Patients states that patients should be triaged within 15 minutes of arrival. Triage is a face-to-face contact with a patient to prioritise their need for further assessment and treatment in a system where the demand for patient care outstrips the ability of the system to deliver it at the time of presentation. A triage and streaming system was in place that aimed to prioritise patients, so they could receive the right care at the right time in the right place. After booking in at reception, patients were called to talk to the streaming nurse at a window at the ED reception. The streaming nurse asked clinical questions and identified patients who could be seen at the urgent care centre (another service based on site but

managed by another provider). They also allocated patients to a triage queue or directed patients straight to resus if they had very urgent care needs. Following concerns identified at previous inspections, we imposed regulatory conditions of the trusts' registration which required them to operate an effective triage process. This was to enable better awareness among staff as to the clinical acuity of patients who self-presented to the department.

- The trust was legally required to submit information on a routine basis detailing how they were meeting these conditions and to explore any potential harm caused to patients who may not have been initially assessed within a timely way. We used this information as a means of gaining assurance that patients were being clinically assessed within an appropriate timeframe. However, we noted during an inspection of the service in November 2019 that there was ambiguity as to the time being recorded on the patient's CAS card, which was used by local leaders to compile the section 31 returns. Staff reported that once a patient had seen the streaming nurse, this time was recorded on the CAS card. However, due to the nature of the mixed streaming/triage process used in the department, the streaming nurse was not able to clinically assess a patient as they had no location to undertake vital sign observations to facilitate an appropriate triage assessment. Whilst those patients who looked extremely unwell could be expediated to majors, or to the resuscitation room, those patients who presented with mild symptoms of chest pain, or had underlying deranged vital signs for example, may not have been so easily detected, especially if a patient was in a clinically compensated state (the body has inherent survival mechanisms which are triggered during periods of critical illness for example. These processes are often only sustainable for short periods of time, and once exhausted, the body succumbs to the symptoms of the underlying illness. This compensatory mechanism can initially mask the actual acuity of a patient and can mislead health professionals if the underlying cause is not quickly identified, resulting in patients rapidly deteriorating). The trust subsequently reported they only monitored the time it took from patients booking in to being streamed, rather than the time from booking in to triage. Trust data showed the average time to streaming between August 2018 and October 2019 was 20.5 minutes. This meant the trust was consistently not meeting the 15-minute triage standard for adults. On 17 February 2020 we observed there to be limited numbers of patients self-presenting to the emergency department. This meant patients experienced minimal waits between booking in with reception staff and being seen by the streaming nurse. We observed one example whereby a patient who appeared acutely unwell was transferred direct to the resuscitation room once they had been seen by the streaming nurse.
- However, during the inspection we observed the streaming and triage process and whilst there were minimal waits for patients to be seen by the streaming nurse, patients referred to be seen by the triage nurse often waited periods of 18 minutes or more before they had a set of observations completed; this was despite the waiting room being relatively quiet on the day of the inspection. Staff reported it was not unusual for the triage nurse to be redeployed to other parts of the department, resulting in less experienced healthcare support workers undertaking the triage process. This was observed to be the case on the day of the inspection. We noted on one occasion a patient had a delay of one hour 29 minutes between being streamed and being called to see the triage nurse. A second patient had waited 33 minutes during a period of low activity. This suggested that when busy, patients could expect to wait extended periods of time before nursing staff could ascertain a baseline for the patient, to aid the developing an appropriate triage protocol.
- We further noted concerns with the use of triage categories in the absence of vital signs being readily available to the streaming nurse. For example, one was triaged as a category green (clinical review within two hours) despite the triage nurse recording an initial early warning score of nine. This would have placed the patient as a category one (immediate clinical review). The patient waited one hour from time of arrival to being clinically assessed by a senior clinical decision maker. This meant there remained a risk the most critically ill patients may have been delayed in being clinical treated by a senior decision maker.
- We had previously raised concerns that patients arriving by ambulance were often delayed in being clinically assessed and handed over. This meant there was a risk acutely unwell patients may not have received time critical care and treatment. To address ongoing challenges, the trust had previously created a four-bed pit-stop area. This

area was used to allow for patients arriving by ambulance (and on occasion, patients who self-presented who appeared extremely sick) to be rapidly assessed by a senior nurse. During this inspection, we observed this process working well. Patients were received, in general, in a timely way by the pitstop nurse. Clinical interventions including electrocardiograms (ECGs), blood tests and other assessments were carried out quickly. We observed instances when the nurse was sufficiently concerned about the condition of a patient and subsequently escalated the patient to medical staff who then carried out timely assessments of patients.

- In the period leading up to and during Christmas 2019, the hospital was experiencing high numbers of ambulances which were delayed by more than 60 minutes from arrival to handing over patients. Data shows peaks and troughs in the number of ambulances delayed during this time period ranging from five to 28 ambulances each day. There was then sustained improvement between 15 January 2020 and 29 January when fewer than five ambulances were delayed daily. Peaks in activity were then noted thereafter with up to 15 ambulances delayed by more than 60 minutes, daily. During the inspection, ambulances were offloaded, and patients handed over in a timely way. However, staff reported that there were occasions when ambulances were required to cohort their patients, or experienced delays in handing their patients over. We asked staff to describe the process for providing clinical oversight and to outline the assessment pathways for patients who were cohorted and who could not be handed over. We were told there was currently no standard operating procedure for the oversight of the ambulance queue. Nursing and medical staff reported they would not routinely review those patients in the ambulance queue unless a paramedic or technician were concerned about the patient and therefore escalated their concerns to the nurse in charge. This presented a significant clinical risk and was contrary to national guidance issued by NHS Improvement in 2017 ("Addressing ambulance handover delays: actions for local accident and emergency delivery boards"). This mandates that "The patient is the responsibility of the ED from the moment the ambulance arrives outside the ED, regardless of the exact location of the ambulance".
- Medical staff had been assigned a sepsis bleep and the bleep numbers was displayed throughout the department. Staff reported the individual carrying the sepsis bleep was required to wear an orange arm band which provided a visual alert for staff in the department. However, during the inspection, we observed the armband to be stored at in a box at the majors control hub.
- Nursing staff had access to nationally recognised risk assessment tools including the national early warning scoring system (NEWS2), Waterlow skin risk assessment tools and sepsis six care bundles. The national early warning score (NEWS2) and the paediatric early warning score (PEWS) were designed to help clinical staff 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). Whilst staff were commencing sepsis screening tools for patients, they did not consistently follow trust protocols. We noted examples where the working diagnosis of patients was sepsis despite staff having initially screened the patient as being low risk, and despite their being single parameters of two or more at initial assessment. There was sporadic use of the NEWS2 tool. Where patients had met the criteria for hourly monitoring, as part of the NEWS2 escalation and management protocol, there was sporadic compliance noted from the comprehensive review of the clinical notes we considered during the inspection. This included one patient who presented with generalised weakness; their initial early warning score was recorded as four. A sepsis screen had been completed which marked the patient as being at low risk despite the EWS flagging two in one single parameter; this should have prompted nursing staff to continue the sepsis screen to rule out any potential red flags. Two hours after arrival, the patient was clinically assessed where it was identified the patient had a red flag for sepsis (high lactate). The sepsis bundle was subsequently completed two hours after arrival. However, antibiotics which had been prescribed on commencement of the second review of the sepsis bundle were not administered for another two hours (four hours after arrival to the ED). This was contrary to best practice standards.
- We further noted delays in the administration of medicines; national early warning scores completed infrequently and contrary to trust protocol; and patients identified as being at high risk of pressure damage through Waterlow skin

assessments, remaining on trolleys for extended periods of time with no active mitigations. This included one elderly patient who had been recognised as being at very high risk of skin damage, in part due to already having a sacral pressure ulcer, remaining on an assessment trolley for 22 hours. Nursing documentation was poor and did not describe the routine skin care provided to this patient. This was contrary to national guidance which states: The National Institute for Health and Care Excellence, Clinical Guideline 179: Pressure ulcers: prevention and management recommend that patients identified as being at "High risk" should be supported to be repositioned every four hours and that the frequency of repositioning should be recorded. Another patient was at "Very high risk" which would therefore suggest the patient should be repositioned more frequently to reduce the likelihood of them sustaining pressure damage. We raised our concerns about this patient with the senior nurse, the nurse-in-charge and the clinical site team. The initial response from one senior member of staff, when we highlighted the fact the patient already had a grade two pressure ulcer was "It will probably be a grade three ulcer now". We considered this to be an extremely poor response from a senior member of staff. On our escalation, the patient was subsequently found a side room on a ward and was transferred from the ED.

- A second patient had also been identified as being at very high risk of skin damage, with a Waterlow score of 20. Again, this patient remained on an assessment trolley with no additional protective measures in place for a period of 22 hours. Again, there was no routine documentation to demonstrate how nursing staff had met the needs of the patient through regular repositioning and skin care being provided.
- One patient had been admitted to the clinical decision unit during the early hours of 17 February 2020. The patient was categorised as being vulnerable due to having learning disabilities. Clinical staff had identified the patient has having previously been diagnosed with Parkinson's disease, for which they were time critical medicines to help manage their symptoms. We noted that despite there being a contemporaneous note of the diagnosis, staff had not considered sourcing or prescribing the time critical medicines for the patient. When inspectors met with the patient, they noted the patient to have significant tremors. Fortunately, a frailty consultant had also identified the patient and took swift action to prescribe their time critical medicines. When we met with the patient later in the day, their tremors had stopped, and the patient was more comfortable. We found other occasions whereby acute medics were prescribing regular medicines for patients who were being held in the ED due to a lack of beds in the hospital. However, nursing staff were not consistently sourcing those regular medicines, therefore impacting on individual patient's drug therapies. This was not recognised as an area of concern by the local leadership team, who attributed failings in care to poor hospital flow. Fundamentally, the lack of comprehensive nursing care could have impacted negatively on the safety and welfare of patients who experienced extended stays in the emergency department. We asked the member of staff responsible for caring for the patient with Parkinson's disease, whether the omission to prescribe and administer time critical medicines had been reported as a clinical incident in order that future incidents could be prevented. They reported they had not been able to report the incident due to time constraints. This was a missed opportunity for the department to learn from a significant event and therefore posed risks to other patients who may present with chronic conditions for which they require time critical medicines to control symptoms.

Nursing staffing

The service did not have enough permanent nursing staff with the right qualifications, skills, training and experience to consistently keep patients safe from avoidable harm and to provide the right care and treatment. However, staffing gaps were filled with temporary bank and agency staff.

- The service did not have had enough permanent nursing staff to keep patients safe. There was a very high reliance on temporary bank and agency staff. This was observed to be the case during the inspection. We spoke with four agency nurses, some of whom had been allocated a set block of shifts to support the ED. Each agency nurse reported they

were familiar with the department. They could describe the actions they would take in the event a patient deteriorated, including the use of the NEWS2 system, as well as being able to identify the location of resuscitation trolleys. Although agency staff did not have access to electronic systems, therefore hindering their ability to view x-ray reports for example, each agency nurse could describe who they would liaise with to gain access.

- Local leaders reported they had completed a baseline staffing assessment to determine the numbers of nursing and health support workers required to safely manage the department. It was reported this assessment was carried out using the Royal College of Emergency Medicine Baseline Emergency Staffing Tool (BEST). The local nurse manager reported there had been a reduction in the number of nurses deployed during the day from 16 to 12. They reported nursing staff were allocated as follows for day shifts
- 1 nurse was supernumerary as department co-ordinator
- 1 nurse streaming
- 1 nurse in resuscitation
- 1 nurse in clinical decision unit
- 1 nurse in pit stop
- 2 nurses to support the corridor
- 1 nurse in triage
- 3 nurses to support the major's cubicles.
- 1 nurse allocated to care for children.
- The BEST tool uses a range of predefined patient dependency ratios to determine the number of staff required each shift. The local leadership team were not able to confirm whether these criteria had been used as part of the BEST assessment as only one nurse was assigned to the four bedded resuscitation area. BEST recommends that a patient who meets the criteria for total dependency requires two nurses to care for them, whilst a patient who was high dependency should expect to receive one to one nursing care. These assessments and ratio's were based on a validated patient acuity tool. We explored further the nurse establishment assessment to ascertain exactly the basis on which it was carried out. It was not clear from the number of nurses deployed across the department, how a baseline assessment of 12 nurses during the day, reducing to ten overnight had been based. This was on the basis that patients in the resuscitation area were or could be extremely unwell, and thus meet the criteria for high or total dependency. Nursing staff reported the resuscitation area was regularly full with four patients and that at times, extremely sick patients required significant nursing and medical intervention however only one nurse and one healthcare support worker was assigned to the area.
- We observed during the inspection that at times of extremely high acuity and department activity, the triage nurse was moved to support the resuscitation room, having been replaced with a healthcare support worker. An agency nurse who had been assigned to provide care to six patients along the corridor had also been informed they were likely to be moved to the resuscitation area, therefore leaving two nurses to provide care to 16 patients in the corridor, with the support of one health support worker. As the day progressed, there was no requirement to move the agency nurse from the corridor, however staff reported they did not consider the staffing ratio's to be correct which impacted on their ability to provide effective nursing care.
- During the inspection we observed the clinical decision unit to be unattended despite there being five patients allocated across the two rooms. This included one patient who was receiving intravenous antibiotic and fluid therapy, and who had been found by inspectors in a state of unkemptness and having been incontinent of urine.

Urgent and emergency services

- The trust reported they required 14 Band Seven nurses, 63 band six, 53 band five and two practice development nurses to safely staff both emergency departments. At the time of the inspection, there were four vacant band seven posts (29% vacancy rate); 23 band six posts (36.5% vacancy rate), 39 band five posts (73.5% vacancy rate) and both practice development roles were also vacant (100% vacancy rate). The trust reported adverts for the band seven roles had attracted 11 applications with ten individuals shortlisted for interview. 12 applications had been received for the band six roles with nine individuals shortlisted for interview. Eight individuals were shortlisted for interview on 27 February 2020.
- The trust reported they were undertaking an extensive overseas nurse recruitment campaign directed at closing the high band five vacancy gap. Six nurses had arrived in to the UK on 5 December 2019 who were shortly followed with an additional 48 nurses. Six nurses had undertaken their observational scenario clinical examinations to enable them relevant registration with the Nursing and Midwifery Council, and therefore the legal ability to work in the UK as a nurse. A further nine nurses were scheduled to undertake the OSCEs on 14 February 2020. The trust anticipated that by May 2020, 106 overseas nurses would have arrived. A further overseas pipeline of OSCE ready nurses had recently been interviewed from which 28 had been identified as being suitably competent to work in the emergency departments across the trust.
- As at December 2019, the trust reported that of the 9,816 total nursing care hours required to provide care and treatment, 591 hours had remained unfilled. Despite the use of temporary staffing, this meant the department remained understaffed by 3.6 whole time equivalent nurses through December 2019.
- In total, 47% of care hours were covered through temporary staffing arrangements, 6% of care hours were unfilled, and 46% were covered through substantive staffing arrangements. 20% of care hours in December were covered through block-booked agency staff; 14% through adhoc agency and 13% supported through bank staff cover.
- The trust did not have enough children's nurses to meet the June 2018 Royal College of Paediatrics and Child Health guidance, Facing the Future: Standards for children in emergency care settings. There were not enough children's nurses employed by the trust to ensure two children's nurses were available on each shift. An ongoing recruitment programme was in place to try and address this. The Care Quality Commission recognises the challenges of recruiting enough numbers of qualified and competent children's nurses to provide continuous emergency care services which meet the RCPCH standards. This is also recognised as a challenge within the standards themselves. However, providers must ensure they recruit and deploy enough numbers of staff with the right skills, training and competency to provide safe and effective care. The standards state that providers should ensure that where there are recruitment challenges, it is essential that a flexible workforce is developed whereby staff are competent and safe to care for infants, children and adults and that this should include emergency care skills.
- We asked local leaders whether adult nursing staff had received any additional training or completed recognised competency frameworks to help them to care for infants, children and young people. We were informed that no such competency framework existed at the trust. We raised this as a significant area of concern with the trust executive team. They subsequently reported they were acting to ensure there were enough numbers of nursing staff each shift to meet the needs of children. We continue to monitor this closely with the trust and system partners and will take appropriate action if we identify further concerns.

Medical staffing

The service did not have enough permanent medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

- The service did not have had enough permanent medical staff to keep patients safe. There was a very high reliance on agency and locum staff. The trust was commissioned to provide type one and type two emergency care services

across two acute locations, Royal Shrewsbury Hospital and Princess Royal Hospital in Telford. At the time of the inspection, the trust employed six whole time equivalent consultants against an anticipated establishment of 20. However, because of long term sickness and maternity leave, only four consultants were available across the two emergency departments to provide consultant presence.

- There was a rolling advert for emergency care consultants, and also a long term plan for the trust to recruit suitable individuals to gain their certificate of eligibility for specialist registration (CESR) (a General Medical Council initiative which supports doctors to register as a consultant, first having joined a specialist registrar, when individuals have either trained in non-approved posts or they have entered an approved training post at a later starting point and completed the rest of the programme and gained the remaining competencies).
- An interview had been scheduled for 24 February 2020 for one candidate for the role of substantive consultant.
- The department was supported by four further locum ED consultants who had been booked until at least March 2020; a further one locum consultant was scheduled to start with the trust on 26 March 2020.
- The trust did not have a Paediatric Emergency Medicine (PEM) consultant as recommended in the June 2018 RCPCH guidance, Facing the Future: Standards for children in emergency care settings.
- The trust did not meet the Royal College of Emergency Medicine (RCEM) Workforce Recommendations 2018: Consultant Staffing in Emergency Departments in the UK which state a consultant should be present in the ED for a minimum of 16 hours a day (8:00am – 00:00am). At RSH consultants worked in the ED Monday to Friday between 8:00am and 8:00pm and 9:00am and 4:00pm at weekends. On call consultant cover was provided at all other times.
- The trust required 32 middle grade doctors to support the emergency care departments across both hospitals. At the time of the inspection, the trust had 14 fully competent middle grade doctors and an additional ten who were supernumerary. The trust anticipated that by June 2020, there would 18 fully competent middle-grades, with an additional twenty supernumerary doctors, totalling 38. These projections were based on successful overseas recruitment campaigns. Overseas recruits had been supported with relocating to the UK including support in sourcing accommodation, English language development courses and support from the consultant body. Each recruit was to be allocated a named consultant responsible for induction, clinical development and pastoral care.
- There were 28 junior doctors working across the two emergency departments. The trust projected that, to facilitate an increase in activity to 130,000 attendances annually, 36 junior doctors were required to safely staff the emergency departments. It was reported a business case was in the process of being finalised to secure the required increase in junior doctors.

Is the service caring?

Inadequate

Our rating of caring stayed the same. We rated it as inadequate because:

Compassionate care

The service was not designed or delivered in a manner that respected patients' privacy and dignity. Staff did not always have the time to interact with people in a meaningful way.

Urgent and emergency services

- We had previously reported that patients in the ED were not consistently supported to receive their care and treatment in a dignified manner. Due to bed capacity challenges at the trust the ED was routinely very busy with patients regularly being nursed on trolley's in corridors. This remained the case at this inspection where 16 patients were nursed in the corridor of period of up to 24 hours during the inspection on 17 February 2020. Patients and visitors were free to walk around the ED as all areas were freely accessible which meant patients on trolleys in corridors were very visible. This included patients who appeared dishevelled and patients who had to lie flat and still in receipt of full spinal immobilisation. Again, these were areas which had previously been highlighted to the trust following previous inspections. We also noted one frail elderly patient who had sustained significant facial injuries following a fall being nursed in a side room. The room remained poorly lit and the door left opened for extended periods of time. Not only did this promote a negative atmosphere within the room, but the patient also reported increasing levels of anxiety because they were disorientated to the time of day. The patient also reported feelings of embarrassment because people walking past their room could see the patient in a dishevelled state and with visible injuries.
- Private areas were not always available, and we saw that patients who received care in corridors were not offered the use of privacy screens when interventions such as taking bloods was completed.
- Staff did not always promote patients' rights to privacy. The ED booking in window was located adjacent to the streaming window so conversations from both windows could be overheard by patients and people visiting the ED. This included patients having to disclose sensitive personal information to the streaming nurse such as their presenting complaint. The privacy and dignity of patients had not been considered by staff despite this having been an area of concern previously raised by the Commission following previous inspections.
- Patients reported nursing staff were kind but clearly rushed and extremely busy. This included one patient who had been moved to the corridor. Despite being in considerable discomfort through the need to use the toilet, nursing staff handed the patient a urine bottle. There was no consideration to the patient's privacy, with nursing staff expecting the patient to urinate in to the bottle whilst in the corridor with other patients present. Due to the patient's discomfort, they were observed attempting to try to go the toilet. We raised this with the nurse responsible who reported the patient had been moved to the corridor for closer observation; this was despite the patient having been discharged and was waiting for transport home. We requested the nurse found the patient a more suitably private area in order their privacy and dignity was protected.
- We also noted one vulnerable adult with learning disabilities. We initially found the patient having been incontinent of urine. The patient was unable to call for help because whilst their call bell was within reach, it had been disconnected from the wall socket. Despite having been in the department for almost 24 hours, the patient remained in soiled clothes for the duration of their stay. Further, although the patient was being nursed on a hospital bed, the patient continued to wear their shoes. No efforts had been made by staff to make the patient more comfortable, or to change the patient in to clean clothes or a hospital gown for example.

Is the service responsive?

Inadequate

Our rating of responsive stayed the same. We rated it as inadequate because:

Access and flow

Urgent and emergency services

People could not always access the service when they needed to, and they did not always receive the right care promptly. Waiting times from arrival to treatment and arrangements to admit, treat and discharge patients fell well below national standards.

- The trust used the NHS England operational escalation framework referred to as Operational Pressures Escalation Level (OPEL). OPEL provides a nationally consistent set of escalation levels, triggers and protocols for hospitals and ensures an awareness of activity across local healthcare providers. Escalation levels run from OPEL one; the local health and social care system capacity is such that organisations can maintain patient flow and are able to meet demand within available resources through to OPEL four; pressure in the local health and social care system continues to escalate, leaving organisations unable to deliver comprehensive care. The trust executive reported the system as being on OPEL two at the time of the inspection. National criteria define OPEL two as "Four-hour access target being at risk of compromise; the local health and social care system is starting to show signs of pressure. The local accident and emergency delivery board will be required to take focused actions in organisations showing pressure to mitigate the need for further escalation". Further examples of OPEL two within the national framework are described as "Anticipated pressure in facilitating ambulance handovers; insufficient discharges to create capacity for the expected elective and emergency activity; opening of escalation beds likely; infection control issues emerging; lack of beds across the trust; ED patients with Decision to admit and no action plan". OPEL three is described as "Four-hour access target significantly compromised; significant numbers of handover delays; patient flow significantly compromised".
- There was a general lack of awareness or understanding of the OPEL tool among local clinical leaders. The senior nurse reported they completed regular department risk safety assessments in the department; we observed the assessment being completed at approximately 12:30. The assessment included the number of patients in the department and their locations. The tool was very generic and provided an indicative risk score of amber. This was despite there being 16 patients on the corridor and the resuscitation area being full. There were nine patients in the department with decisions to be admitted but no hospital capacity to move them to inpatient beds. Both the senior nurse and senior doctor in charge felt the department was more aligned to a black status with patient safety compromised due to limited space in the department. The tool had been sourced from another NHS organisation and local leaders were not aware whether the tool had been adapted to ensure it met the needs of the ED at Royal Shrewsbury Hospital, which may have explained the difference in reported acuity and the perceived acuity among the leadership team. This mis-match between the reported and actual acuity had the potential to introduced inherent risks and false assurance as the information was considered at the operational site meetings.
- An escalation process was in place to enable ED staff to monitor and escalate access and flow problems within the ED. However, staff told us this tool was not always used in line with local guidance due to capacity issues and other pressures within the department. This meant acute changes in access and flow may not always be escalated in a prompt and effective manner. Further, local leaders did not feel the escalation protocol led to any noticeable improvement in terms of resolving patient flow in the department. Executive visibility in the ED was reported to be poor. During the inspection the Director of Nursing was undertaking one of her visits to the Emergency department, she introduced herself to the lead CQC inspector at the time and invited them to contact her at any time should the need arise, or if they needed. We observed no further presence from any of the executive team thereafter.

Median time from arrival to treatment (all patients)

- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust consistently failed to meet the standard and performed worse than the England average over the 12-month period from August 2018 to July 2019. The percentage of patients who were seen and treated by a senior clinical decision maker within 60 minutes from arrival between 23 December 2019 and 2 February 2020 was reported as 23.8%. This was significantly worse than the England average between the same period.

Urgent and emergency services

- The average time to treatment was reported as 111 minutes for November 2019. This had increased from 94 minutes when compared to November 2018.

Number of patients waiting more than 12 hours from the decision to admit until being admitted

- In December 2019, a total of 348 patients waited between more than 12 hours from the decision to be admitted being made, to the patient being transferred to a bed, compared to one patient in December 2018.
- Patients could not always access inpatient care from the ED in a timely manner, which meant this patient cohort stayed in the ED for longer than they should have. The trust did not consistently record and monitor the numbers of patients in receipt of corridor care.

Percentage of patients admitted, discharged or transferred within four hours from arrival

- The Department of Health and social care standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department. From September 2018 to August 2019 the trust consistently failed to meet the standard, and consistently performed worse than the England average.
- The percentage of patients who were admitted, discharged or transferred within four hours from arrival between 23 December 2019 and 2 February 2020 was 70% (includes type 1, type 2 and type 3 cases) (6-week average). Trust wide, for the duration of December 2019, performance against this metric (for all attendance types) was reported as 60.5% which was worse than the data reported for December 2018 (65.5%)
- The percentage of patients who met the “Majors” criteria who spent less than four hours in the emergency department in December 2019 was 52.5%. This was worse than the trusts previous performance for December 2018 which was reported as 58.4%.
- In 2018/2019, NHS Improvement set an initiative in which it was expected all acute NHS trusts in England with a type one emergency department would have an established acute frailty service, providing at least 70 hours of cover each week (NHS Improvement: Same-day acute frailty services). A significant proportion of the patients present in the ED during the inspection were aged over 65 years. Staff reported this was representative of the local demographic and was consistent with the referral and attendance patterns seen in the ED. Despite there being significant numbers of frail elderly patients in the department on a regular basis, and considering the poor departmental flow, resulting in patients remaining in the ED for extended periods of time, the trust had been very slow to implement a robust and well-staffed frailty in reach service. During the inspection we met with a frailty care consultant who was providing in-reach services to the ED and clinical decision unit. The consultant worked in silo and did not have dedicated access to a wider team as mandated by NHS Improvement. Although there was adhoc access to physiotherapists and occupational therapists, the team did not work collectively to provide a timely multi-disciplinary assessment for frail patients, thus reducing the opportunities for patients to avoid admission. This is in no way a criticism of the local clinical team who were working hard to assess patients but was symptomatic of a wider lack of traction to instigate evidence-based care models mandated by NHS Improvement/NHS England.

Is the service well-led?

Inadequate

Our rating of well-led stayed the same. We rated it as inadequate because:

Urgent and emergency services

Leadership

Leaders did not have the skills and abilities to run the service in a safe and effective manner. Leaders did not understand and manage the priorities and issues the service faced. Senior leaders were not always visible and approachable in the service for patients and staff.

- Despite the Care Quality Commission having inspected and reported against the full key lines of enquiry, as set out in published standards, which detailed the necessary areas for improvement, there remained a significant and profound lack of progress to address longstanding concerns within the department, and wider emergency care pathway. Local leaders did not recognise the serious shortfalls in the quality of care provided in their emergency department. There was a lack of situational awareness, further hampered by poor governance and risk management processes.
- Despite their being a visible presence of leaders in the department, there was a generalised acceptance and blindness to the substandard level of care, provided to frail patients. This included a general acceptance of nursing high risk patients on trolleys for extended periods of time. Nursing staff of all grades considered that due to the design of the mattresses, frail, high risk patients could remain on assessment trolleys for periods of up to 22 hours without there being any tissue damage. This contradicted national best practice guidance which requires that alongside mechanical interventions such as the use of pressure relieving devices, patients at risk of skin damage should also be regularly repositioned and that records of care are maintained to support this. These interventions were absent during the inspection and had not been challenged by senior clinical leaders. Further, nursing staff had not considered the wider implications of patients being nursed for extended periods on trolleys; this included the generalised discomfort associated with the narrow nature of the trolley as an example.
- The local leadership team reported that shortfalls in the consultant workforce had contributed to a lack of change of culture in the department. Further, workforce challenges meant there was limited ability to change governance processes in order there was enough reporting of issues to effect systemwide change.
- Staff reported a sense of isolation and exclusion from the executive team who were described as being “dismissive” of the challenges faced in the emergency department. The lack of robust safety metrics and elements of false assurance perhaps contributed to the perceived lack of seriousness or impact faced by the emergency team and associated care provided.
- The long-standing clinical director was absent on a period of extended leave resulting in another consultant acting-up in to the role. The role of clinical director was being advertised internally, for which we were told there were two existing members of staff who were interested in applying. However, what was apparent through the inspection was a noticeable lack of engagement between the consultant parties across the two emergency departments. There was an element of stubborn behaviour displayed by individual members of the team which added to the lack of progress made across the emergency departments. Staff reported concerns that in the event of an internal appointment being made, there would continue to be a lack of progress on one site over another due to a perceived lack of engagement from consultants at the ED for which they did not work at.
- The nursing leadership team advocated for cross site working with some members of the team undertaking rotational posts across the two emergency departments to help better understand the variations in the quality of services. Six-month rotation programmes had been established for the band seven cohort. These individuals spoke candidly about the variations with the team at Princess Royal Hospital where staff considered the team there to be more forward-thinking, innovative and demonstrating a wanting to change the status quo.
- Operational nursing leadership at a local level was poor. There was a lack of escalation to more senior trust executive team members where there had been identified and continuing omissions in care. Nursing staff were not acting as advocates for patients as mandated by the Nursing and Midwifery Council Code of Practice which states that all registrants must “Put the interests of people using or needing nursing of midwifery care first… make their care and safety your main concern and make sure that their dignity is preserved, and their needs are recognised, assessed and

responded to". Nursing and medical staff were not consistently reporting incidents to help improve care and to learn from when things had gone wrong. There was a general culture of the unacceptable becoming normal. We noted multiple occasions where by frail elderly patients were being nursed on assessment trolleys with both the head and feet of the trolley tilted, thus acting as a subtle form of restraint. This was due to patients not being able to easily move or re-position themselves. In addition, extended waits on assessment trolleys, omissions in administering routine medicines, poor compliance with sepsis care bundles and a failure to meet the individual needs of patients were all suggestive of institutional failings.

Vision and strategy for this service

The service did not have a clear vision for what it wanted to achieve or an effective strategy to turn it into action. However, senior leaders engaged with stakeholders regarding the planning of future ED services.

- There was no specific vision and strategy specifically dedicated to urgent and emergency care services at the trust. Staff spoke of a departmental philosophy which was orientated towards placing the patient at the centre of the service. However, our findings of this inspection, married with previous inspection findings suggested there was little commitment to the departmental philosophy.
- The trust reported the emergency divisional care group continued to work with system-wide partners including representatives from the Emergency Care Intensive Support Team (ECIST) and NHS Improvement to develop a clear vision and strategy for both the intermediate and long term.
- Departmental leaders spoke of addressing longstanding workforce challenges, as well as having a department which was fit for purpose as the two most pressing concerns which were impacting on the overall quality of the service. Whilst the trust had introduced same day emergency care models for ambulatory patients, as well as establishing an acute medical assessment unit, the service operated a very traditional emergency care model. Frailty pathways had not been fully considered despite there being a national mandate. A lack of capacity for the local team to take time away from clinical duties to focus on wider system improvement plans had been given as the reasons for a lack of robust vision or strategy. Changes and interim appointments to the executive team were also cited as an obstacle to the change agenda.

Governance, risk management and quality measurement

Leaders in the ED did not operate effective governance processes throughout the service. The service did not always identify, escalate and mitigate relevant risks and issues.

- Departmental governance and risk management strategies were ineffective and were not sufficiently resourced to ensure local leaders were aware of, and therefore assured by the quality of services provided. An on-going commitment to undertake regulatory imposed evidence returns, a lack of substantive workforce and a lack of capability within the local team were all citied as contributory factors, which further hampered the development of robust governance processes.
- Local leaders were not fully sighted on the risks associated with the department. There was a reactive attitude to risk management, likely because of there being insufficient dedicated time afforded to the right people with the right skills to undertake robust reviews of governance and quality metrics within the department.
- There was a lack of capacity for the local team to undertake a fresh perspective of the overall quality of care being provided. Some staff had only ever worked at Royal Shrewsbury Hospital and so lacked the insight in to how emergency care and associated care models had progressed over time. Rotational programmes were reported as being well received by senior nurses as it had afforded them an insight in to another emergency department.
- Although cross-site governance meetings took place monthly, there was limited evidence of change because of these meetings. Some referred to the governance meeting as being a "Tick-box exercise" which "Afforded no real change".

Incidents, complaints and regulatory conditions were considered as part of the governance process however, in reality, there remained little change to practice. Serious incidents had been discussed however actions identified were often lack-lustre and insufficient to drive improvements. This included a serious incident in December 2019 when a patient's presenting complaint was not effectively managed. Routine physical observations had not been carried out on the patient in the lead-up to their cardiac arrest. Our review of NEWS2 charts continued to show sporadic compliance with the NEWS2 frequency rules. There was limited evidence in medical and nursing notes of when patients had been escalated in response to an increase in NEWS2 scores. Further, we noted one example where there had been evidence of nursing staff escalating their concerns to the medical registrar on three occasions however there had been no response. The patient was subsequently transferred to the coronary care unit for on-going management instead of waiting for the medical registrar to review the patient in the ED. These were all examples of where there had been a lack of robust governance processes to underpin changes to practice across the emergency department.

- There had been a lack of progress to upskill nursing staff to ensure they were competent to manage children and young people. One member of nursing staff reported there was no requirement for them to be upskilled as they considered children to simply be "Small adults". Infants, children and young people have different physiological, emotional and psychological stages of development and therefore health professionals require extensive experience to safely manage this cohort of patients. We considered the statement of the nurse to be ill-considered and was suggestive of a standard attitude towards the management or infants, children and young people.
- Senior leaders in the department had little awareness of the risks associated with the emergency care service. There was limited insight in to the risks which were captured on the departmental risk register. Senior leaders afforded differing views as to the risks of the department. Whilst medical and nursing staffing were referenced and indeed included as departmental risks, there was limited insight in to the lack of children's nurses. There was limited insight from local leaders in to how nursing establishments had been calculated, which meant little assurance could be taken from the ratio of nurses deployed each shift versus the needs of patients accessing the service. The trust executive team however reported that staffing establishments had been calculated with the support of ECIST, using their recognised staffing model. This assessment was submitted to the public board in May 2019 and included a rationale for the staffing numbers and details of the model used and how the establishment was reached.
- Others described consultant recruitment, the clinical decision unit not being fit for purpose, emergency care exit blocks (including a need to increase the number of nurses deployed to meet the needs of patients as well as an increase in demand), a focus on improving performance against constitutional standards and a requirement for speciality teams to accept responsibility for their patients, were all considered as risks. The wider aspect of quality of care within the department; compliance with trust protocols and practices and at a more basic level, the delivery of fundamental care standards was not seen as risks associated with the ED.

Culture within the service

Staff did not always feel respected, supported and valued.

- We observed some hostile behaviour from one senior manager towards a member of the local ambulance trust who was operating as the Hospital Ambulance Liaison Officer (HALO). The HALO reported they had been "Told off" twice already during their shift for occupying a space at a desk during a period when there were no ambulances waiting to be offloaded. Whilst the HALO reported being resilient, we considered the trust representative was not abiding by the trust values and behaviours, nor were they treating the individual with respect.
  - Staff reported low morale across the department. Two staff spoke candidly about seeking new job opportunities outside of the trust. Their motivations included a perceived lack of progress to improve the existing nursing establishment; concerns over the quality of care provided; a lack of time to spend with patients, meeting their needs and providing holistic care.

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Areas for improvement

Action the hospital MUST take to improve

Ensure that staff comply with nationally recognised infection control standards. Regulation 12(1)(2)(h) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Ensure patients are risk assessed in a timely way and that risks associated with the delivery of health care is mitigated as far as is reasonably practicable. Regulation 12(1)(2)(a)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Ensure there are enough numbers of staff across all professions and grades with the right skills, competency and experience, are always employed and deployed . This includes but is not limited to ensuring there are enough numbers of competent staff to care for infants and children. Regulation 18(1)(2)(a)

Ensure staff comply with local early warning systems to ensure patients at risk of deterioration are recognised and treated within defined time scales. Regulation 12(1)(2)(a)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Ensure patients can access care and treatment in a timely way. Regulation 12(1)(2)(a)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Ensure there are robust governance processes in place which assist in evaluating and improving the quality of care provided to patients accessing the emergency care pathway. Regulation 17(1)(2)(a)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Ensure patients requiring time critical medicines are clinically assessed and such medicines are prescribed and administered in a timely way. Regulation 12(1)(2)(g) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Ensure patients, including those who present with mental health concerns, are managed in an environment which is fit for purpose. Regulation 12(1)(2)(d) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Ensure the privacy and dignity of patients is protected at all times. Regulation 10(1)(2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Our inspection team

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

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

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

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

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

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
Treatment of disease, disorder or injury	Section 29A HSCA Warning notice: quality of health care