Southend University Hospital NHS Foundation Trust

Southend University Hospital

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Southend University Hospital is an established 700 bed general hospital and provides a range of services to a local population of some 338,800 in and around Southend and nearby towns. The trust provides a range of acute services including acute medical and surgical specialties, general medicine, general surgery, orthopaedics, ear, nose and throat, ophthalmology, cancer treatments, renal dialysis, obstetrics and gynaecology and children's services. Southend University Hospital is the South Essex surgical centre for uro-oncology and gynae-oncology surgery. The trust achieved Foundation Trust status in 2006.

We inspected this hospital on 7 August 2014 in response to concerns of stakeholders and information of concern received into the CQC. Southend University Hospital NHS Foundation Trust was found to be in significant breach of its terms of Monitor authorisation since 2011-2012 due to their failure to demonstrate that there were appropriate arrangements in place to provide effective leadership and governance. There were also concerns around the trust's failure to meet cancer and C. Difficile targets.

This was a responsive review undertaken by six inspectors from CQC and two specialist advisors in A&E and governance practices. Only the services within the A&E department and the governance structures at Southend Hospital location were inspected. We have identified that the service was not compliant with some regulations following this inspection. We have not rated the service as this was a focused inspection however a further comprehensive inspection will be undertaken in the future to determine ratings of all services within the trust.

Prior to the CQC on-site inspection, the CQC considered a range of quality indicators captured through our intelligent monitoring processes. In addition, we sought the views of a range of partners and stakeholders.

The inspection team make an evidenced judgment on five domains to ascertain if services are:

- Safe
- Effective
- Caring
- Responsive
- Well-led.

Whilst we noted some good practice there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Improve its cleaning schedule within the A&E department.
- Improve the security and storage of medicines within the A&E department.
- Increase the number of permanent trained nurses, paediatric nurses and consultants within the A&E department.

In addition the trust should:

- Take prompt action to ensure that the children's A&E department is in line with national guidance.
- Review working with the psychiatric liaison services to improve the care provided to patients within the department.
- Ensure that there are robust systems in place for checking stock to ensure it is in date and safe to use within the A&E department.
- Review the management and directorate structure which supports A&E to improve clinical excellence.
- Improve on the overall achievement rate of doctors attending mandatory training.
- Ensure that all doctors within the A&E department have received children's safeguarding level 3 training.
- Review the process for equipment reported as faulty within the service, ensuring it is repaired or replaced in a timely manner.

Summary of findings

- During this inspection we found that the essential standards of quality and safety were not being met in some areas. As a result of our findings we have issued the trust with compliance actions. We have asked the provider to send CQC a report that says what action they are going to take to meet these essential standards.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services		We spoke with 24 members of staff from various roles including nursing, medical and support services. We spoke with two visiting paramedics who were in the department. We also spoke with three patients and two relatives, one who was waiting with their child. The feedback from the majority of people we spoke with was positive. No concerns were raised with regards to the treatment or care they were receiving. Staff were caring, compassionate and treated patients with dignity and respect and most patients gave positive comments regarding their care. We found suboptimal practices with regards to infection prevention and control. Medicines management was not always undertaken in accordance with national guidelines. For example we observed medicines drawn up in syringes left unattended; staff were unaware of what the medicine in the syringe was or how long it had been there. There were not enough permanent consultants to provide substantive senior cover to the emergency department. There were an insufficient number of permanent nursing staff to adequately cover all shifts and there was a reliance on agency and bank staff for nursing and medical cover. There were insufficient paediatric trained nurses within A&E. There was also no dedicated paediatric department however the trust informed us of plans to create one. Staff were clear on the risks, and areas in the department that needed improvements. Staff we spoke with could articulate the strategy of the hospital and were aware of the long-term plans for the accident and emergency department.

Urgent and emergency services

Information about the service

The Accident and Emergency Department (A&E) at Southend University Hospital saw 89,965 patients in the last year, including approximately 5239 children in the last six months. The service is available 24 hours per day every day of the year.

The department consists of four main areas, an emergency doctor's service, run by a general practitioner, minor injury treatment area, a majors area, which includes a dedicated treatment room for paediatric patients and a resuscitation area. Whilst the department did not have a dedicated clinical decision area for patients who required observation for longer than four hours but are unlikely to need admission, the A&E department did have access to beds within the acute medical unit which were used like a clinical decision area where required.

Summary of findings

We spoke with 24 members of staff from various roles including nursing, medical and support services. We spoke with two visiting paramedics who were in the department. We also spoke with three patients and two relatives, one who was waiting with their child. The feedback from the majority of people we spoke with was positive. No concerns were raised with regards to the treatment or care they were receiving. Staff were caring, compassionate and treated patients with dignity and respect and most patients gave positive comments regarding their care.

We found suboptimal practices with regards to infection prevention and control. Medicines management was not always undertaken in accordance with national guidelines. For example we observed medicines drawn up in syringes left unattended; staff were unaware of what the medicine in the syringe was or how long it had been there.

There were not enough permanent consultants to provide substantive senior cover to the emergency department. There were an insufficient number of permanent nursing staff to adequately cover all shifts and there was a reliance on agency and bank staff for nursing and medical cover. There were insufficient paediatric trained nurses within A&E. There was also no dedicated paediatric department however the trust informed us of plans to create one.

Staff were clear on the risks, and areas in the department that needed improvements. Staff we spoke with could articulate the strategy of the hospital and were aware of the long-term plans for the accident and emergency department.

Urgent and emergency services

Are urgent and emergency services safe?

The department was not clean in all areas. We saw areas that were dusty and had discarded rubbish on tables and floors. We also found some items of equipment that was dusty and stained. Cleaning and checking documentation was not completed on a daily basis.

Prescription medicines were not always stored safely or disposed of appropriately. The environment had limited space. Where refurbishments had taken place, for example in the majors department the area was well designed with the arrangement of cubicles around the nurses station improving care for patients.

There was no recognised early warning system in place to identify deteriorating adult patients. The early warning system aims to ensure timely recognition of deteriorating patients through an agreed set of measurable patient signs. The absence of this tool meant that the service was not acting in accordance with national guidance.

There were substantial nurse and consultant vacancies. The department was reliant on agency and bank staff to maintain staffing levels. The trust acknowledged the numbers and skill mix of nurses was below the expected level. Whilst the trust also acknowledged that the lack of permanent consultants was a risk to the service, they attempted to reduce such risk through the use of long term locum doctors and ensuring that robust escalation plans were in place.

Incidents

- There have been no recent never events reported that relate to this department.
- Incidents were under reported in A&E. Some of the staff we spoke with told us they reported incidents to the nurse in charge and assumed they reported it through the incident reporting system. One member of staff told us they had only reported one incident in the last five months but had discussed more incidents with their senior colleagues in the same period.
- We saw the trust produced a weekly incident round up document. However we saw that the last round up displayed in the corridor outside the staff rest room was dated 28 March 2014. We were informed that the service had planned to improve the 'Did you know' board in the staff room. We viewed this board and saw that work was in progress and there was evidence that changes to practice following incidents was shared. Some of the staff told us they got feedback when incidents were reported.

Cleanliness, infection control and hygiene

- The department was not clean in all areas. Shelving and equipment in the majors and resuscitation area were covered with a film of dust. Cleaning and checking books were attached to some equipment when examined we noted that there were gaps in the checking and cleaning of equipment. For example, the resuscitation equipment in the paediatric bay of the resuscitation area had not been signed as being checked on 11-15 July 2014 and 29 – 1 July 2014. The neonatal resuscitaire had gaps in the checking documentation on 28 and 29 July 2014.
- When we first inspected the neonatal resuscitaire we found it to be dusty and the sheet was stained with blood. This equipment had not been checked the morning of our inspection, however the nurse explained that this would be done when time allowed. We went back to check the area and found the neonatal equipment had been checked, cleaned and the sheet changed.
- The treatment room dedicated to paediatric patients was dusty and filled with equipment. There was a large box of books on the floor. We asked how the books and toys were cleaned. A nurse told us the books and toys in the treatment room and in the paediatric waiting room were cleaned daily.
- We found the paediatric waiting room dirty with sweet and crisp wrappers and empty drink cans on the tables and floors. We viewed the toy cleaning rota and found many gaps in the schedule. For example, there was no signature since 25 July 2014 to confirm the toys had been checked and cleaned. We pointed this out and the task was undertaken immediately and the waiting room was cleaned.
- Several of the toilets we saw did not have toilet roll holders and we found that toilet rolls were placed on the floor which meant that the toilet roll could be contaminated with bacteria.
- Curtains within the department were disposable and clearly dated with the date of the most recent change. The curtains were clean.

Urgent and emergency services

- We saw staff using personal protective equipment (PPE) appropriately and washing their hands between patient contacts. There was also adequate hand gel available within the department though we noted a number of dispensers were empty.
- Staff were bare below the elbows in line with trust policy.
- Foot operated pedal bins were in place for the disposal of waste which was in line with current national guidance.
- The infection prevention and control audit results for July 2014 was displayed in the waiting area. The department achieved 100% compliance with the audit. However from the findings on the day of our inspection we were not assured of the reliability of the audit results because infection control practices were not always adhered to.

Environment and equipment

- We noted that there were only three dedicated adult bays within the resuscitation department which was busy on the day of our inspection. In addition to this there were two paediatric bays, one adaptable to becoming a neonatal bay and the other an adult bay, as required. Staff told us that at times the environment was too small for the number of patients attending. Staff explained that the paediatric area was often used for adult patients.
- The radiology department was situated next door to the unit and was easily accessible. This meant that patients could be seen quickly.
- We checked several pieces of equipment and found them to have been annually serviced and maintained. PAT testing had been completed annually.
- We checked the equipment drawers in the paediatric treatment room in the majors and the resuscitation area. The drawers in the treatment room were disorganised and contained both paediatric and adult equipment. There were bags labelled baby and neonate, which were open and the equipment inside was spilling into the drawer with other equipment. We pointed this out at the time of our inspection and the senior nurse rectified it immediately.
- We found a single use hoist sling, used to support the transfer and movement of patients who are unable to mobilise independently, draped over a hoist. These slings are patient specific and should be kept with the patient at all times. This would pose a significant risk to other patients if used inappropriately for patients of different height and weight. We raised our concerns to a member of staff who disposed of the sling immediately.
- We looked at two commodes. The metal frame holding the toilet bowl in place was corroded and rusty. This posed an infection control risk. A member of staff explained they had been reported on 16 June 2014 but had not been replaced. We confirmed it had been reported. On the day of our inspection the metal frames were replaced.
- Some of the staff were uncertain how faulty equipment was reported and some staff told us that they thought someone else reported faults and ordered replacements. Staff were not sure what happened after they had reported equipment for maintenance or repair.
- The space within the department was limited which meant that there were a number of items in public corridors including beds, trolleys and cages used to transport stock. This can pose a hazard to staff, patients and the public however we recognised that the service was constricted by the space available for use.
- Inside a cupboard, located in the sluice room, were pathology specimen pots which were out of date by six months. We found no robust system for checking the stock within the service to ensure that out of date items were replaced. We brought this to the attention of the staff who replaced the out of date items.
- The majors department had been refurbished within the last 12 months. The area was well designed with the arrangement of cubicles around the nurses station. This meant that all patients were visible to staff and they were able to monitor them.

Medicines

- There was no clinical pharmacy link for the emergency department. However a pharmacist did carry out a stock check twice a week. We spoke with two pharmacists who explained this had been identified as a risk and was on the pharmacy risk register. A business case had been submitted, through the resilience committee, to increase the number of pharmacists. An outcome of this had not been determined at the time of our inspection.
- We saw that a control drug and a storage and security audit had been carried out on 2 July and 27 June 2014. The emergency department had attained 93% and 91% compliance with the audit. This meant that some

improvements were required to ensure controlled drugs were safely managed. On the day of our inspection we noted that controlled medicines were stored securely and records showed that they were properly accounted for.

- The pharmacists we spoke with explained the process for reviewing and implementing actions following medication incidents. All incidents were discussed in the safety action group and reported through to the clinical assurance committee.
- We found a syringe containing a clear fluid discarded on a shelf in the neonatal bay of the resuscitation area. When asked staff were unsure what was in the syringe or how long it had been there. We handed this directly to the nurse in charge to dispose of in line with the trust's medication policy.
- We asked the nurse in charge to show us the emergency resuscitation drugs for paediatrics. They were able to show us two sealed boxes labelled and containing emergency drugs for children. There was confusion amongst the staff as they attempted to locate a black box which they believed contained other emergency drugs. We discussed this with a pharmacist who explained the two boxes we had seen contained all the drugs required in an emergency and the black box had not been in used for many years. Staff were unclear about the correct process and storage of emergency paediatric drugs.
- The emergency drugs in the adult emergency trolley were sealed and in date.
- The sluice door was propped open with a clinical waste bin. Inside the sluice was a cupboard that was unlocked and contained a number of prescription only medicines, specifically phosphate enemas, microlette enemas and suppositories. Therefore these medicines were not stored securely.
- Portable oxygen cylinders where charged and had been serviced in line with manufacturers guidelines.

Records

- We examined the records of six patients on the day of our inspection. We saw that records were appropriately completed by the multidisciplinary team.
- Where patients had a cannula inserted, we saw that a risk assessment had been completed. Risk assessments were in place for patients who required pressure relieving equipment and for those at risk of falls. Where people had attended with injuries, we saw that a full body map was completed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw the training figures for the department up to 30 June 2014. We saw that 75% of medical staff had attended training on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. However the document we saw did not contain any figures for support staff or nurses. We discussed this with the general manager, head nurse and the manager for the business unit. They told us that staff did attend training and these figures were incomplete but were unable to provide more accurate information.
- On two occasions, we saw staff explaining what they were going to do and asked for the patients consent before they proceeded. In patient notes, we saw that patients had given verbal consent before a cannula was inserted.

Safeguarding

- We saw a current safeguarding policy for adults and children, which was accessible on the intranet. The policies were version controlled and the policies reflected national guidance.
- We saw the training figures for the department. 85% of emergency department staff and 40% doctors had attended level two adult safeguarding training. 58% of staff, 67% of administration staff and 43% of doctors had attended level one child safeguarding training. 50% of doctors had attended level one adult safeguarding training. 71% of staff and 30% of doctors had attended training in level two child safeguarding. There were no records available that evidenced that any other staff, apart from doctors, had attended level three safeguarding for children.
- Staff were knowledgeable about what constitutes a safeguarding concern, how to recognise abuse and how to escalate these concerns appropriately. There were safeguarding leads for nurses and doctors and staff were able to name them and told us they were able to contact the leads for advice and support as needed.
- There was limited safety information in public or staff areas though we were aware safety information was discussed at weekly meetings.

Urgent and emergency services

Mandatory training

- We saw that overall 85% of staff had attended mandatory training. This training included training in areas such as, infection prevention and control, moving and handling, induction and cardiovascular resuscitation. The data supplied by the trust showed that only 36% of doctors had attended the training. We asked for attendance at specific training and found gaps in the recording of attendance. For example, according to the data no staff had attended paediatric cardiovascular resuscitation. We spoke with senior management who assured us staff had attended but were unable to explain to us how many had attended.
- Staff confirmed that they had received their mandatory training and were supported to develop their skills. Every Tuesday at lunchtime there were education sessions within the department which staff were encouraged to attend. This included training around observations, x-rays and how to recognise a deteriorating patient. Whilst some staff confirmed that they had attended, others said that they were unable to as the unit was too busy.

Management of deteriorating patients

- There was no recognised early warning system in place to identify deteriorating adult patients. Senior managers confirmed that the trust would be introducing the National Early Warning System, which is used for adults, in November 2014. The early warning system aims to ensure timely recognition of deteriorating patients through an agreed set of measurable patient signs. The absence of this tool meant that the service was not acting in accordance with national guidance.
- The department was however using the national Paediatric Early Warning System for children.

Assessing and responding to patient risk

- There was a dedicated team who attended rapidly to waiting patients to ensure action was taken to promote patient flow according to clinical need. This service was available 12 hours a day, seven days per week.
- The rapid action team included doctors, nurses and support workers who undertook procedures and tests as soon as the need was identified. Staff told us this was a useful process.
- The team had referral pathways to specialist teams in the hospital such as surgeons or paediatric physicians.

Nursing staffing

- We spoke with senior management and they explained that recruitment and retention of staff had been a problem but was slowly improving. The vacancy rate was 3.8 whole time equivalent (WTE) nurses, three WTE emergency nurse practitioners, six WTE band five paediatric nurses and one WTE paediatric lead.
- The trust acknowledged the numbers and skill mix of nurses in the department were suboptimal. Agency and the trust's own bank staff were used to maintain staffing levels. In July 2014 a total of 316 shifts were covered by agency and bank staff, 26% bank staff and 74% agency staff.
- We were informed that agency staff were unfamiliar with the department and are not always provided with induction. We asked to see the induction check lists for agency staff and confirmed that agency staff were given an induction prior to commencing their first shift. We randomly selected three agency staff records and saw their completed induction checklist. The general manager and nurse lead explained they endeavour to use the same agency staff and have a service level agreement (SLA) with the agency. Managers and staff depend on this agreement to ensure that all staff employed from the agency have the correct qualifications and skills to perform the role they have been asked to do.
- The department only had four nurses with specific paediatric qualifications. When they were on shift they would be assigned to oversee the paediatric beds however this was not staffed by appropriately trained nurses at all times. We were told paediatric staff were difficult to attract as the department did not have a specialised paediatric area within the emergency department. The trust had recognised this as a risk and had a suitable action plan in place.
- Senior management had recognised the lack of paediatric trained staff and had identified it as a risk. Plans were in place to rotate paediatric nurses from the children's ward to the department. This was due to start in September 2014. One nurse was booked onto the deteriorating child course in September 2014 and 10 nurses were booked onto the European paediatric life support course. No date for this course was available to us on the day of our inspection.

Urgent and emergency services

Medical staffing

- There were only two full time consultants covering the emergency department. The expectation of the College for Emergency Medicine is that there should be a minimum of 10 but ideally 12 WTE consultants who must be available for at least 14 hours per day. We spoke with members of senior management about cover for the two consultants in the event of an unplanned or sickness absence. We were informed that the impact could be catastrophic to the service.
- The consultants we spoke with told us the consultant posts were at present covered by locum consultants. A total of 288 shifts were covered in July 2014 by agency or bank staff, 74% of shifts were covered by agency staff the remaining 6% was covered by the trust's own bank staff. These figures included 92 consultant shifts.
- The trust had implemented a series of measures to try to attract consultant staff with increased advertising in medical journals. The department had fully recruited to all other grades of medical staff although there were some delays due to working visa clearance for international doctors. It is acknowledged that there are national shortages of emergency department consultants and we found that the service had adopted a number of innovative ideas to develop internal staff or attract external staff to the trust. This included new working rotas and the re-writing of the middle-grade medical contract which included enhanced pay rates for speciality doctors.
- The trust had worked with medical staff to rearrange the rosters to more closely match staff levels with the expected activity at different times of day through the week, including more staff working on night duty. On the day of our inspection safe medical staffing had been arranged to enable induction training of new staff.
- Medical staff told us they felt there was disengagement with fellow consultants within the trust and that patient's care, at times, could be disjointed. Clinical pathways were not always coordinated. The trust had reviewed this and begun to implement a '10 steps' system to promote coordination of patient pathways through the hospital departments. This included an expectation that referrals were accepted and responded to within thirty minutes. Additional pathways such as for elderly frail patients were being established.
- Medical staff told us that a common difficulty was waiting for beds on admitting wards. We spoke with one patient who had been waiting to be transferred for nearly four hours, although we were told a bed was available on the orthopaedic ward. We observed the progress of the transfer for 45 minutes. The patient wasn't transferred and we also noted they were not on a soft trolley mattress.

Major incident awareness and training

- We spoke with the major incident liaison officer who explained they were reviewing the major incident policy. However we saw that there was a current policy for dealing with capacity and demand issues and the escalation process for staff to follow when required to do so.
- We noted that the service had been involved in a recent major incident where the resuscitation department flooded due to torrential rain from storms, patients were moved from the area temporarily. We found that staff responded and acted appropriately at the time, however some staff informed us that there had been no major incident debrief post incident.
- We saw that major incident training sessions had been arranged in June 2014 and six members of staff from the emergency department had attended. We were told further sessions were planned but no date had been arranged at the time of our inspection.
- We also saw that the major incident process had been tested in 2013 and a table top exercise had been undertaken with the local commissioning groups in 2014.

Are urgent and emergency services effective?

(for example, treatment is effective)

Staff within the department were unable to assure us that policies, guidance and processes were monitored to ensure satisfactory patient outcomes.

We observed that the service had established pathways in place to fast track patients with certain conditions. For example fractured neck of femur patients are meant to be fast tracked to the orthopaedic ward for treatment. We found that some medical teams, including paediatrics, were reluctant to review patients in the emergency department in a timely manner.

Urgent and emergency services

The department was meeting the 95% four hour target on the majority of occasions in the weeks preceding our inspection. Compliance with this target had improved greatly since April 2014.

Evidence-based care and treatment

- We randomly selected three policies, which were easily accessible on the trust's intranet. All the policies were current, version controlled and referenced national guidance and recommendations.
- We asked how national guidance was reviewed within the trust. We were told all new guidance was distributed from the corporate governance department to the divisional business units where they were reviewed to determine the relevance to the particular specialty. We were provided with an example of the head injury pathway, which was being reviewed against national guidance.
- We asked to see the department's national and local clinical audit programme. Senior management were unable to tell us what audits were being carried out and how they assured their policies, procedures and guidance were working to improve patient's outcomes.

Pain relief

- We saw that when patients were triaged they were offered pain relief if it was required.
- We examined six sets of patient notes and found that patients had been given pain relief and this was also indicated on the drug chart. However, although the basic assessment of a patient included a pain score, none of the records we reviewed included a completed pain score.
- We observed a patient waiting for transfer to a ward for a considerable length of time. The patient had sustained a significant fracture. They told us that they were in discomfort but had been offered no pain relief.

Nutrition and hydration

- Where patients were unable to drink, we saw that their hydration needs were met through intravenous fluids.

Patient outcomes

- We were advised by staff on the orthopaedic ward that there were fast track arrangements for patients with fractured neck of femur to be admitted from Emergency department onto the orthopaedic wards by specialist orthopaedic nurses or medical staff. However on the day of our inspection one elderly patient with this type of fracture had waited almost four hours on a normal trolley without additional pressure relieving measures.
- The department was meeting the 95% four hour target on the majority of occasions in the weeks preceding our inspection. This is a target set to ensure 95% of patients are seen within four hours of entering the A & E department. Compliance with this target had improved greatly since April 2014. Staff told us that the four hour target was causing extreme pressures to staff. One member of staff however told us that, "Despite pressures because of targets, we always put patient safety first".

Competent staff

- As of June 2014, 22.5% of unspecified staff, 55% of administration staff and 72.73% doctors had received an appraisal. An appraisal is a personal development review of staff's performance objectives and a process for determining staffs' development needs. As part of this supportive programme staff should also receive clinical supervision. We asked for the number of staff who had received supervision. Senior management told us staff did not have clinical supervision.
- Some nursing staff had completed additional training specifically related to the emergency department such as advanced practitioner courses.
- Care assistants working in the department were supported to undertake development including NVQ's.

Multidisciplinary working

- Staff told us there was poor access to psychiatric services, which are provided by another provider. An example was given where a patient with mental health concerns was admitted to the department and seen by the emergency psychiatric service who recommended the patient be sectioned under the Mental Health Act 1983. However the psychiatrist team were unable to review the patient until the next day. The patient was unwell and required one to one care in an inappropriate care setting. Staff told us this had been raised as serious incident.
- We saw positive multidisciplinary working between paramedics when they brought in a patient and handed them over to hospital staff. There was a clear, concise handover of information and each member of the team were clear of their role and responsibilities.

Urgent and emergency services

- A senior member of staff we spoke with told us that some medical teams including paediatrics seemed reluctant to review patients in the emergency department and did not always do so in a timely way. However the General Practitioner (GP) working in the department told us they had no problems in referring patients to other specialties.

Are urgent and emergency services caring?

We spoke with three patients and two relatives, one who was waiting with their child. The feedback from the majority of people we spoke with was positive. No concerns were raised with regards to the treatment or care they were receiving. Staff were caring, compassionate and treated patients with dignity and respect and most patients gave positive comments regarding their care.

Compassionate care

- Curtains were pulled when staff were attending to patients. We saw numerous examples of positive staff engagement with patients.
- Staff who were attending unconscious patients did so with dignity and respect and spoke to them respectfully before undertaking any intervention
- We saw the results from the friends and family test displayed in the corridor outside the staff room. The comments were mixed. For example, patient's comments included, "Five hour wait in agony and tears. No pain relief. Rude receptionist", "Waiting time – not enough doctors", "Cannot praise care enough" and "Nurses helpful and attentive". These comments were from January 2014. We were unable to locate more recent survey results.

Patient understanding and involvement

- Whilst observing staff provide care to patients we saw that staff spoke and cared for patients in a kind and attentive manner. We observed good rapport between the staff and patients.
- One patient asked questions about their condition and we saw the doctor and nurse taking their time in responding and fully answering questions. Staff were positive about working in the department. One nurse told us, "I love working here" and another said, "It's very good working here". We observed a good rapport between staff in the department.
- Two patients we spoke with were very happy and were treated promptly, including one who had to briefly wait to be reviewed by the urology team.

Emotional support

- We saw that there was an area within the department for bereaved relatives. This meant that families had privacy to grieve and their emotional needs were respected.
- Signage was displayed around the department containing information of support services available including chaplaincy, domestic violence and cancer support.

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

There was no dedicated paediatric department and staff often used the paediatric equipped treatment room and bay for adult patients.

There was a GP streaming service which had improved the flow in the emergency department. Patients were seen by the GP within 15 minutes of entering the department. The majority of patients on the day of our inspection were discharged back to the community setting.

Service planning and delivery to meet the needs of local people

- There was an escalation policy and escalation flow chart displayed in the majors area of the department. We observed how the escalation policy was to be used when the capacity within the department reached a peak. Feedback on department capacity was also fed back at bed meetings held throughout the day. This meant that the trust was aware of the risks around service capacity and demand throughout the day.
- On the day of our inspection there was an alert that the ambulance crew were exceeding their waiting time targets. This was escalated to the general manager and the issues were addressed.

Access and flow

- The department used GP streaming to identify patients who required emergency treatment or those that could be treated more appropriately elsewhere. The GP saw

patients within 15 minutes of them entering the department. On the day of our inspection we saw that the GP had triaged the majority of patients as being able to receive care in the community.
- We spoke with a charge nurse in minor injuries area. On the day of our inspection there was a very short wait to see patients. Staff told us that patient flow had improved since the creation of the GP service.

Meeting people's individual needs

- There was a specific room for patients with mental health problems to be assessed in a more comfortable environment outside of the main department.
- There were no established ambulatory care pathways in place within the department. We were informed that the department were working towards this.
- There was a stroke pathway in place. We observed two stroke patients being assessed and managed in line with national guidance. For example the patients were seen by a dedicated stroke team shortly after admission to the department.
- There was no dedicated paediatric department, although there was an area equipped for paediatric and neonatal patients in the resuscitation area and one treatment room in the majors area of the department. However staff told us these were often used for adult patients when the department was busy. This meant that children were being treated in the same areas as adults which is outside of national recommendations.
- There were plans to develop a paediatric department but we were unable to establish a date when this would commence. A dedicated department would allow all children to be seen and treated in an appropriate environment and by dedicated paediatric staff.

Are urgent and emergency services well-led?

Staff were clear on the risks, and areas in the department that needed improvements. Staff we spoke with could articulate the strategy of the hospital and were aware of the long-term plans for the accident and emergency department.

Whilst the trust supported the active recruitment campaign, staff told us that the lack of trust staff on duty was impacting the service and the pace of recruitment was too slow. Locally the department did not have a sufficient staff structure in place to ensure the service was well led. Whilst staff locally had no concerns regarding clinical leadership, the lack of permanent consultant staff meant that education and mentorship provision was not consistently provided.

Vision and strategy for this service

- Staff we spoke with were aware of the future plans for the department and the strategy to improve the service. Staff provided us with examples including the opening of a dedicated paediatric A&E service.
- We found that staff spoke of the vision and values the trust has implemented. Overall we found that staff working in the department worked with pride and identification.
- The morale within the department was upbeat however staff spoke to us about how pressured the service was because of the low staffing levels and four hour targets.

Governance, risk management and quality measurement

- The service sat within the medicine business unit. There were dedicated managers, a matron and a clinical lead for the A&E department.
- The department held internal governance meetings which both nursing and medical staff attended. Incidents were reviewed across the medicine business unit.
- The department risk register was maintained and escalated to trust level as required.

Leadership of service

- None of the staff we spoke with raised any concerns with the local clinical leadership within the department.
- We found that the messages from the leadership team at senior and executive level were not always filtering to the department through the business units. For example following the recent major incident within the service we were informed by the executive team that a debrief meeting took place with the service leads. However the local department staff were unaware that one had taken place.
- We spoke with the senior management within the department, who were unable to answer all of our queries and requests for information. Their response on numerous occasions was that a senior member of staff, who was unavailable on the day of our inspection, would have been able to answer our queries and would have access to the information requested. There was an

over reliance on one member of staff to have an overview of the department as a whole as well as the medicine service. We did however note that the trust were in the process of changing this structure. A new senior manager and general manager had been in post for two weeks and a new operational a manager was due to start employment shortly.

- There were only two consultants permanently employed by the trust. This meant that doctors in training and middle grade doctors could not always access senior consultant support and leadership.

Culture within the service

- Only one member of staff we spoke with told us that there was a bullying culture within the department and that they did not feel supported in their work. However the majority of staff were positive about working in the department. One nurse told us, "I love working here" and another said, "It's very good working here". We observed a good rapport between staff and saw no evidence of a bullying culture during our inspection.
- One support worker explained how they had raised concerns to the nurse about a patient and how the nurse was quick to respond and praised them for doing so. Staff told us that they felt well supported and respected by managers.

Public and staff engagement

- Two members of staff told us they received unit meeting minutes regularly and that these meetings and the Tuesday education sessions held in the department, provided an opportunity for staff to feedback on areas that were working well or needed improving. They explained that senior staff encouraged feedback. One support worker told us they had recommended that more staff, particularly nurses should be able to cannulate. The support worker had since undertaken cannulation training and was rolling out a cannulation workshop to train other staff.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must improve its cleaning schedule within the A&E department.
- The provider must improve the security and storage of medicines within the A&E department.
- The provider must increase the number of permanent trained nurses, paediatric nurses and consultants within the A&E department.

Action the hospital SHOULD take to improve

- The provider should consider improving the environment for children in the A&E department to ensure that care is provided in line with national guidelines.
- The hospital should improve working with the psychiatric liaison services to improve the care provided to patients within the department.
- The provider should ensure that there are robust systems in place for checking stock to ensure it is in date and safe to use within the A&E department.
- The provider should improve the management and directorate structure which supports A&E to improve clinical excellence.
- The provider should improve on the overall achievement rate of doctors attending mandatory training.
- The provider should ensure that all doctors and relevant staff within the A&E department have received children's safeguarding level 3 training.
- The provider should ensure that the equipment reported as faulty within the service is repaired or replaced in a timely manner.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control People who use services and others were not protected against the risks associated with infection because of inadequate maintenance of appropriate standards of cleanliness and hygiene within the A&E department. Regulation 12 (2) (c)(i) HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and Infection Control.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People who use services and others were not protected against the risks associated with the unsafe use and management of medicines because the medicines were not stored securely and were not always disposed of appropriately within the A&E department.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing There were an insufficient number of suitably qualified, skilled and experienced trained nurses and consultant doctors within the A&E Department.