

The Princess Alexandra Hospital

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out an unannounced focused inspection of the emergency department at The Princess Alexandra Hospital on 3 February 2020 in response to concerning information we had received in relation to the care of patients in this department. At the time of our inspection the department was under increased pressure.

We did not inspect any other core services or wards at this hospital. During this inspection we inspected using our focused inspection methodology. We did not inspect or rate all key lines of enquiry at this inspection.

This was a focused inspection to review specific concerns relating to the emergency department. The inspection took place between 12 pm and 7.30 pm on Monday 3 February 2020.

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

- The trust must ensure sufficient provision of out of hours endoscopy service to minimise risk of treatment delay to patients who require to access the service.
- The trust must ensure detailed up to date records are kept in relation to provision of care and treatment and it is reflective of each patient's full clinical pathway and include actions taken in response to individual risks.
- The department must ensure there are always enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care.

Professor Edward Baker

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Rating

Summary of each main service

Requires improvement



We carried out an unannounced focused inspection of the emergency department in response to concerning information we had received in relation to the care of patients in this department. At the time of our inspection, the department was under increased pressure. We did not inspect any other core services or wards at this hospital. During this inspection we inspected using our focused inspection methodology, focusing on the concerns we had. We did not inspect all key lines of enquiry. However, we did rate elements of the service at this inspection.

We rated safe as requires improvement because there were insufficient systems and processes in place to manage specific risks to patient safety. Staffing levels were still not sufficient and records did not always contain all necessary information related to a patient's care and treatment. Well-led was rated as requires improvement because governance systems were not robust and the leaders had failed to identify appropriate actions to mitigate known risks and continued non-compliance.

Summary of findings

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Requires improvement 

The Princess Alexandra Hospital

Services we looked at

Urgent and emergency services

Summary of this inspection

Background to The Princess Alexandra Hospital

We previously inspected the emergency department at the Princess Alexandra Hospital in March and April 2019. We rated it as requires improvement overall. Following this inspection, we issued one requirement notice and told the provider that they must take specific actions to ensure patient safety. We found significant concerns and risks to patients within urgent and emergency services which we raised with the trust at the time of inspection on 3 February 2020. Following the inspection, we undertook enforcement in respect of urgent and emergency services to enable the improvement of safety within the service. We issued a warning notice under Section 29A of the Health and Social Care Act 2008 on the 7 February 2020 and told the trust it must improve by 8 March 2020.

Urgent and emergency care services at the Princess Alexandra Hospital are provided 24 hours per day, 365 days per year. The department consists of a resuscitation area, majors, rapid assessment and treatment (RAT), the clinical decisions unit (CDU), urgent treatment centre where patients could see general practitioners (GP; employed by another provider) and reception areas which included streaming area. A separate paediatric emergency department facility is adjacent to the main department. This is staffed by registered children's nurses and treats children under the age of 16 years.

Our inspection team

The team that inspected the service comprised of a CQC inspector, and two specialist professional advisors with expertise in urgent and emergency care. The inspection was overseen by Bernadette Hanney, Head of Hospital Inspection.

Why we carried out this inspection

We carried out an unannounced focused inspection of the emergency department at The Princess Alexandra Hospital in response to concerning information we had received in relation to care of patients in this department.

How we carried out this inspection

We did not inspect any other core service or wards at this hospital. We inspected the emergency department using our focused inspection methodology. We did not inspect all key lines of enquiry; however, we did rate elements of this service at this inspection.






Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Urgent and emergency services

Safe	Requires improvement 
Effective	Good 
Caring	Good 
Responsive	Requires improvement 
Well-led	Requires improvement 

Summary of findings

We did not inspect the whole core service. However, there are ratings associated with this inspection. We found that:

- There was insufficient provision of out of hours endoscopy service.
- Staff did not always record actions taken in response to individual risks.
- Managers did not ensure records were up to date and that they were reflective of each patient's full clinical pathway.
- The department did not always have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care.
- The service did not always act promptly to ensure risks were eliminated or reduced.
- People could not always access the service when they needed it and received the right care promptly.

However:

- The design, maintenance and use of facilities, premises and equipment kept people safe.
- Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had managers at most levels with the right skills and abilities to run a service providing high-quality sustainable care.
- Staff and managers across the service promoted a positive culture that supported and valued one another.

Are urgent and emergency services safe?

Requires improvement 

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.

The service had suitable equipment which was easy to access and ready for use.

Staff told us they had equipment to enable the assessment of patients including adults, and children. They felt that equipment was of good quality and reliable, and when they identified faulty equipment it was repaired promptly.

The equipment we checked had servicing and electrical safety stickers on indicating it was safe to use for the designated purpose. Staff told us the equipment used by them was modern and well maintained. Clinical staff knew where to find the equipment they needed to respond to an emergency and had received appropriate training to enable effective use of it.

Resuscitation equipment was readily available and easily accessible. The hospital had systems to ensure it was checked regularly, fully stocked, and ready for use.

Overall the department was visibly clean and tidy. It was well maintained.

Assessing and responding to patient risk

Urgent and emergency services

Staff completed risk assessments for each patient swiftly. Staff identified and quickly acted upon patients at risk of deterioration. However, staff did not always record actions taken in response to individual risks.

Staff had training in areas such as mental health, elderly care, paediatrics. They received training in managing emergencies, including managing sepsis and life support training, appropriate to their role. It included immediate life support training for both adults and children. Senior nurses completed advanced life support training. Specialist children nurses, in addition, had advanced life support training qualifications. Staff present in the resuscitation area had advanced life support qualifications.

Between June and December 2019, the emergency department was steadily increasing in their time from arrival to initial assessment for patients arriving by ambulance. The trust's figure in June 2019 was eight minutes but in November 2019 it was approximately 17 minutes which was slightly longer than the recommended 15 minutes. However, information provided post inspection demonstrated that the trust was performing well in comparison to others in the East of England region. In addition, the emergency department had an allocated hospital ambulance liaison officer (HALO) on site seven days a week, 10 hours per day supporting ambulance handover processes.

Staff used a nationally approved tool to identify patients at risk of deterioration and escalated them appropriately. The national early warning score (NEWS2) and the paediatric early warning score (PEWS) were used to identify deteriorating patients in accordance with National Institute of Health and Care Excellence (NICE) Clinical Guidance (CG) 50: 'acutely ill adults in hospital: recognising and responding to deterioration' (2007). We saw NEWS2 charts were completed correctly and regularly. The nursing staff we spoke with were aware of how to escalate patients when their condition was deteriorating. The emergency department was supported by the intensive care unit or the critical care outreach team in cases when a patient's condition was deteriorating and where patients had difficulties with breathing and required invasive intervention.

Staff completed risk assessments for each patient on admission/arrival, using recognised tools, and reviewed

these regularly. However, we saw that on occasions action taken to mitigate risks identified were not recorded. For example, when a high risk of pressure ulcer was identified. Overall, patients' medical records were of poor quality and did not provide full information about the care and treatment provided by nursing and medical staff. Out of the seven paper records we reviewed, none had information about discharge; however, staff told us this information could be sourced from electronic records. Records did not always detail the complete care and treatment plans for patients. For example, two of the records did not show what actions had been taken for patients who were identified as being at high risk of developing pressure ulcers. In four records, hourly observations had not been completed.

Staff used both paper and electronic systems to record patient care. They told us that mixture of paper and electronic records meant that information could not always be easily found – as different information was contained on different systems; this could lead to errors. This also meant that accessing various systems limited the time clinicians could spend providing direct clinical care and potentially delay the patient's treatment.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about the patient's mental health condition). Staff completed or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

There was no effective protocol to ensure patients could promptly access endoscopy service in emergency cases during out of hours. The trust had not responded to incidents which indicated improvements were required in out of hours endoscopy service provision.

Doctors told us staff allocated to the trauma rapid response team outside of the ED did not always treat trauma calls as a priority which potentially could delay the care and treatment provided to trauma patients. We were unable to assess the effectiveness and response times of the team and were unaware of incidents where potential delayed trauma team's responses negatively affected care and treatment.

The trust scored about the same as other trusts for the five emergency department survey 2018 questions

Urgent and emergency services

relevant to safety. It included questions related to waiting with the ambulance crew before care was handed over to the emergency department staff (score 8.1) or waiting for examination (score of 6.2).

The hospital had emergency protocols, and staff were aware of them. They also had protocols guided by the Public Health England for dealing with infectious diseases outbreaks. For example, for responding to infectious diseases for example coronavirus (COVID-19).

Information was available to help staff identify patients who may become septic. Sepsis is a serious complication of an infection.

Nursing staffing

The department did not always have enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care.

The department was unable to fully cover nursing and healthcare assistant rota and staff told us they frequently worked with less than planned staff on shift. On the day of our inspection, the day rota fill rate was 93% for nursing staff and 90% for healthcare assistants (actual staffing levels compared with planned). The department was expecting to work with below 100% staffing during the night (correspondingly 92%- and 96%-night shift fill rate).

The department had 25 vacant posts for junior nurses and five for senior nurses. However, this was linked to the increased number of posts allocated to the department after the staffing levels review which took place in 2019. The review led to an increase in the number of nursing posts available in the emergency department.

Nursing staff were allocated to start work at different times throughout the day. Starting times and staffing levels correlated to predicted patients' attendances based on historical data and prediction modelling used in the department. Senior staff had oversight of the staffing within the department and moved staff around to ensure all areas were safe and they were able to manage surges in demand.

When temporary staff were used to cover short notice issues such as sickness and likely increased demand, they received formal induction to the department. The department aimed to use bank or agency staff they knew and who were familiar with the department.

There were sufficient registered children's nurses to cover shifts at the paediatric department. There was always at least one nurse who had received paediatric immediate life support training on duty. Nursing staff rotated between paediatric ED and children's wards and staff from children's ward could provide support to the department should there be a need to fill uncovered shifts.

Medical staffing

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

The emergency department was reliant on temporary medical staff, especially during the out of hours period. To help mitigate risk, there was a process in place where all locum curriculum vitae's (CV) were reviewed by senior consultant prior to the individual being booked for shifts.

However, the staff we spoke with told us some of the temporary staff who had worked in the department did not always have sufficient clinical experience or skills. They felt this could potentially put patients at risk during out of hours and that this negatively affected staff morale. We were not aware of any reported incidents which would be directly linked to the use of temporary staff in the emergency department.

The department undertook a medical staffing levels review in 2019 which led to increasing numbers of consultants. They identified there was a requirement for 11 consultants to work in the department to provide sufficient 16 hours a day cover. At the time of our inspection, there were nine whole-time equivalent (WTE) emergency department (ED) consultant posts filled, including those who worked in the paediatric ED. Information provided post inspection was that a 10th consultant had been appointed. We were informed after the inspection that proactive recruitment of middle grade doctors was ongoing, with appointments offered. The trust were hopeful that this grade would be fully recruited to establishment levels by August 2020.

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ED leaders told us they were in a process of recruitment, however, as they struggled to find suitable candidates, they were required to fill posts with fixed-term doctors who were trained overseas. Doctors we spoke with were worried about the length of time needed to provide transitional training to ensure new doctors were familiar with the systems and clinical pathways practised in the UK. Doctors also said that the hospital did not offer similar development opportunities or work benefits as some of the neighbouring trusts and this made it difficult to compete when trying to fill vacant posts.

We were informed post inspection that the trust offered a variety of programmes to support new doctors such as an additional induction programme specifically for international medical graduates. We were also informed that existing non training grade emergency physicians were offered support to meet certificate of eligibility for specialist registration (CESR) competencies

Senior doctors told us a consultant was present in the department for 16 hours a day, seven days a week from 8 am until midnight. Staff told us that frequently doctors worked past midnight to respond to the increase in the number of patients visiting ED.

Medical staff were allocated to start work at eight different times throughout the day. However, shift starting times were not always driven by capacity and demand. This led to the concern that staff may ineffectively use time through repetition of handover processes.

Doctors main handover took place twice a day and at other occasions, doctors were updated on any issues on an individual basis. The department planned to review the rota patterns in 2020 to ensure it directly correlated to predicted patients' attendances based on historic data and prediction modelling used at the department.

Registrar doctor was available 24 hours a day. Consultants led the treatment of the sickest patients. They provided out of hours on-call support.

Junior doctors spoke positively about working in the emergency department. They told us that consultants were supportive and always accessible.

As the department saw over 25,000 children a year there was one consultant with sub-specialist training in paediatric emergency medicine.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good 

We did not inspect against this key question.

Are urgent and emergency services caring?

Good 

We did not inspect against this key question.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Requires improvement 

Access and flow

People could not always access the service when they needed it and received the right care promptly.

The percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average in six of the 12 months of 2019.

The percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was consistently when compared to the England average.

In 2019 the trust's monthly median total time patients spent in ED was higher than the England average.

There were some systems in place to manage the flow of patients through the emergency department (ED) to discharge or admission to the hospital. The operations control room and clinical site team could see on the IT system the length of time patients had been in the ED, who had been referred and required admission. The

Urgent and emergency services

system allowed them to have an overview of bed availability and the flow of patients coming into the ED. This was all discussed at regular bed meetings throughout the day.

The department saw the number of attendances increase by 7% between September 2018 and August 2019 (109,978) when compared with the previous 12 months period. During the same period, the department decreased number of hospital admissions by 13%.

The department organised daily meetings which were attended by members of the imaging department, ambulance service, staff from medical and surgical wards, operational leads and senior doctors and nurses working in the ED. These meetings were also frequently attended by a member of the trust's executive team. This is where staff discussed any capacity issues and how to resolve them as well as any untoward events that could affect the department's flow.

Improvements had been made in the initial streaming and triage processes for patients who self-present to the ED. The process had improved patient experience and it had a direct impact on patients being triaged in a timely way. Moving the streaming area, from one part of the waiting room to another, improved the clinical oversight of the waiting room.

The introduction of the rapid assessment and treatment unit (RAT) improved the flow within the department. RAT had four cubicles, which were staffed with a nurse and a healthcare worker who could assess patients and direct them to other clinicians when appropriate.

The use of escalation areas and the clinical decisions unit was not in line with the trust's policy. On occasions, the department used corridors of the majors' department and the clinical decision unit (CDU) for a time longer than allowed by the service's operational protocol. The facilities available for patients who waited in the department for long periods of time were not always appropriate. For example, when patients stayed overnight on the clinical decision unit a bed was not always provided to them. Instead, they were required to stay on a hospital trolley.

Patients did not have access to a shower facility in the CDU and hot food was not routinely provided if the

patient stayed on the unit for less than 24 hours. Information provided after our inspection demonstrated that patients could access hot food if required, on an individual basis.

The hospital collected information related to treatment in non-designated areas, such as corridors, and used it to monitor patterns as well as to inform commissioners in their periodic performance reports.

Staff told us they experienced some challenges with coordinating clinical pathways within other hospital departments, such as the outpatient department, who did not always provide patients with rapid access to specialist care without going through the emergency department. Instead on occasions patients were directed to the emergency department from outpatient clinics which affected service provision to walk-in patients or those that arrived by ambulance.

The trust was also experiencing increased ambulance handover delays of 30-60 minutes. In November 2019, 72% of ambulances had turnaround times above 30 minutes. The turnaround time is an interval between the time of ambulance arrival at the hospital and the time the ambulance becoming available to respond to another call. From June to November 2019 there was a slight upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at the hospital (from 61% to 72%).

The department's unplanned re-attendance rate within seven days was slightly better than the England average of 8% in the same reporting period.

Managers and staff worked to make sure patients did not stay longer than they needed to. The Department of Health's 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 January 2019 to December 2019 the trust failed to meet the standard and performed worse than the England average. However, they steadily improved their performance between February and November 2019. The trust's four hours performance in January varied between 60% and 80%.

The percentage of patients waiting more than four hours from the decision to admit until being admitted at the Princess Alexandra Hospital NHS Trust was worse than the England average in six of the 12 months of 2019. Over

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the 12 months from January 2019 to December 2019, 27 patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in April and December of 2019 with 10 patients each of those months exceeding the 12 hours wait.

From December 2018 to November 2019 the monthly percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was consistently worse at 4.5% when compared to the England average of 2.5%.

From January 2019 to December 2019 the trust's monthly median total time patients spent in ED, for all patients, at 188 minutes was higher than the England average of 163 minutes. We noted that the performance was slightly improving since April 2019.

The clinical site team provided 24 hours a day cover, seven days a week. They had oversight of acute and emergency flow, along with ensuring capacity was maintained. Patients had access to diagnostic procedures when necessary.

Are urgent and emergency services well-led?

Requires improvement 

Leadership

The service had managers at most levels with the right skills and abilities to run a service providing high-quality sustainable care.

The trust had recruited into local leadership posts which had a positive impact on staff morale. There was a new associate medical director who commenced employment in 2019. The department was awaiting the appointment of a new head of nursing who had been recruited at the end of 2019. In addition, they had recruited to two matron posts to ensure improved oversight and management of the department.

Operational managers knew the department well and were aware of issues related to day to day management. The department also had two clinical leads who had worked within the department for many years.

Staff told us that executive team members visited the department numerous times throughout the week and frequently participated in their daily huddles.

Vision and strategy for this service

Plans for the future vision had been developed with involvement from staff, patients.

The department had escalation plans that could be brought into effect during the period of increased pressures on the department. These were designed to ease pressures and improve access and flow within the department and throughout the hospital.

Governance, risk management and quality measurement

The service had a systematic approach to continually monitor the quality of its services. The department had systems for identifying risks, however, they did not always act promptly to ensure these were eliminated or reduced.

When concerns were identified these were escalated to local managers who took actions or sought further advice from the trust's executive team.

There was insufficient oversight of the quality of records and the managers failed to address the issue which we brought to the trust's attention at our previous comprehensive inspection in 2019. Although, the sample of records was audited daily by a senior emergency department (ED) nurse we noted that records were not always completed and did not always provide a full view of the patient's clinical pathway.

The trust did not always ensure that prompt action was taken, and learning was implemented in response to serious incidents. Despite being aware of risks related to a lack of provision of out of hours endoscopy service leaders had not taken sufficient action to mitigate those risks to prevent potential future incidents.

The use of escalation areas and the clinical decisions unit was not in line with the trust's operational policy. On occasions, the emergency department utilised the clinical decision unit for a time longer than allowed by the service operational protocol.

Culture within the service

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Staff and managers across the service promoted a positive culture that supported and valued one and other.

Staff demonstrated a compassionate and caring attitude. They mostly spoke positively about the service and were proud to work for the trust. However, they said the relationship between ED and other departments of the hospital needed to improve.

Staff within ED told us communication across various specialities and divisions within the hospital needed improving and there was a potential for improved joined

working to improve patient experience. We observed good interactions between different staff who worked within the ED as well as those from other hospital's departments.

Staff told us overall the department was a good place to work and described it as having an open culture and felt they could approach managers if they felt they needed to seek advice and support. They felt they could provide good care.

Doctors told us it was difficult to fully involve the temporary staff working in the department in the day to day running of the ED. They felt having more permanent staff would contribute positively towards the culture of the department.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

- The trust must ensure sufficient provision of out of hours endoscopy service to minimise risk of treatment delay to patients who require to access the service.
- The trust must ensure detailed up to date records are kept in relation to provision of care and treatment and it is reflective of each patient's full clinical pathway and include actions taken in response to individual risks.
- The department must ensure there are always enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care.

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	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <ol style="list-style-type: none">1. Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.2. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to-<ol style="list-style-type: none">a. assess, monitor and improve the quality and safety of services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);b. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;c. maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;f. evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e). <p>Staff did not always record actions taken in response to individual risks. Managers did not ensure records were up to date and reflective of full patients pathway.</p>

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

Treatment of disease, disorder or injury

Regulation

Section 29A HSCA Warning notice: quality of health care

A warning notice was served under Section 29A of the Health and Social Care Act 2008.

1. The trust has not taken actions to mitigate the risks associated with the lack of endoscopy services out of hours.
2. The trust has not taken enough action to ensure that records of care and treatment are clear, up to date and easily accessible