

# Worcestershire Acute Hospitals NHS Trust

## Evidence appendix

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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

## Acute services

### Urgent and emergency care

#### Facts and data about this service

The emergency department (ED) at Worcestershire Royal Hospital provides a 24-hour, seven day a week service. It is a designated trauma unit but patients with multiple trauma are taken directly to the major trauma centre in Birmingham. 70,000 patients attended the ED in the year ending October 2017; of these attendances approximately 14,000 (20%) were children under the age of 16.

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

The service has been inspected twice in the last year; a comprehensive inspection in November 2016 and an inspection to follow-up concerns in April 2017. The trust has been issued two Section 29A Warning Notices under the Health and Social Care Act 2008. Section 29A Warning Notices

are issued when a trust is required to make significant improvement in the quality of care provided. Concerns with the ED were raised in both Warning Notices, which were issued in January and July 2017.

During our inspection, we spoke with 11 patients and two family members, reviewed records of 25 patients and spoke with 16 staff. We also reviewed the trust's ED performance data. We inspected the whole core service, looked at all five key questions and followed up concerns from the Warning Notice.

## Is the service safe?

### Mandatory training

There were trust-wide issues with mandatory training data collection that had been occurring since we inspected in November 2016. Previously, the emergency department (ED) was unable to provide information on the number of staff who had completed mandatory training. This was a breach of regulations and the trust was issued a requirement notice for Regulation 18 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014 Staffing.

Staff received mandatory training in safety systems, processes and practices. Mandatory training for staff consisted of a range of topics, which included health and safety, information governance, conflict resolution, equality and diversity and infection prevention and control. Courses for mandatory training were delivered online or via face to face sessions.

Compliance with mandatory training did not meet the trust target of 90% in the majority of modules. Not all nursing staff had received basic or intermediate life support training.

Data provided by the trust showed the overall compliance with mandatory training for ED staff was 73% in September 2017, which was below the trust target of 90%. However, training records held in the ED showed that additional training had recently taken place and staff were now compliant with the trust target. Therefore there was an inconsistency in the data held.

The table below shows the ED data provided by the trust did not meet the target for compliance with any of the nine modules included, except for manual handling where compliance was 93%. The figures shown is the percentage of staff that were up to date with that module.

Staff group	Conflict resolution	Equality and Diversity	Fire	Health and Safety	Infection Prevention	Information Governance	Manual Handling	Preventing Radicalisation	Resuscitation (Basic life support)	OVERALL
Medical staff	61%	35%	57%	48%	100%	57%	100%	17%	61%	60%
Nursing staff	84%	62%	76%	90%	60%	92%	87%	100%	92%	83%
Administrative staff	61%	61%	50%	94%	59%	94%	93%	94%	n/a	76%
Average compliance	69%	53%	61%	77%	73%	81%	93%	70%	77%	<b>73%</b>

(Source: Routine Provider Information Request (RPIR) –P40 Training Tab)

Nursing staff were required to complete basic life support (BLS), intermediate life support (ILS) and paediatric intermediate life support (PILS) training; however, not all nursing staff were up to date with this at the time of inspection. Nursing staff compliance with BLS was 92%, ILS was 77% and PILS was 76%.

Some nurses (60%) had undertaken advanced life support (ALS) training, in addition to their role requirements.

Medical staff were required to complete life support training up to advanced level (ALS). At the time of inspection, all medical staff had completed ALS and emergency paediatric ALS. Compliance with advanced trauma life support was 83%. Medical staff compliance with European Paediatric Advance Life Support was 100%.

Staff from the mental health liaison team provided training to nurses, which included the use of a mental health matrix to determine level of risk and the most appropriate environment for the patient within the ED. Mental health training was also included in the inductions for junior doctors and newly recruited nurses. Training was led by staff from the mental health liaison team and the trust's alcohol liaison nurse.

## **Safeguarding**

After the inspection in April 2017, the trust was issued a Warning Notice for breaching Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2014: Safeguarding service users from abuse and improper treatment. This was because safeguarding training compliance was below the trust target and the level of safeguarding training for senior staff did not meet national guidance.

Staff compliance with safeguarding children's training did not meet national recommendations, however staff understood how to protect patients from abuse.

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. There was a clear system and process in place for identifying and managing patients at risk of abuse. Nursing staff we spoke with were able to explain the process of safeguarding a patient and provided us with specific examples of when they would do this.

Information provided by the trust on safeguarding training compliance reflected the local information held by senior ED staff. This meant the trust had an accurate central record of safeguarding training compliance.

Staff compliance with adult's safeguarding training met the trust target. All medical staff and 95% of nurses had received training in level 2 adult safeguarding.

For September 2017 data showed medical staff compliance with safeguarding children level 3 was 83% and for nurses it was 78%. Senior staff told us that the remaining 20% of staff were new and were waiting for a training course to be arranged. Training included information to help staff identify women or children at risk of female genital mutilation. Compliance was not in line with national requirements. The Royal College of Paediatrics and Child Health Safeguarding children and young people: roles and competences for health care staff intercollegiate document 2014 states all clinical staff involved in assessing, planning and treating children and young people should be trained to safeguarding children level 3.

The table below shows safeguarding training data provided ED staff and data requests:

Staff group	Safeguarding Children Level 2	Safeguarding Children Level 3	Safeguarding Vulnerable Adults Level 2
Medical staff	100%	83%	100%
Nursing	47%	78%	95%
Overall compliance	74%	81%	98%

Although safeguarding children's compliance did not meet the trust target, all staff we spoke with understood how to protect patients from abuse. They were aware of their responsibilities to report safeguarding concerns and knew whom to contact for advice. Staff described examples of when they had raised safeguarding concerns in the past and knew what actions to take to protect vulnerable adults and children, including those at risk of female genital mutilation.

Senior nurses had access to the child protection information sharing system that was used by GPs and safeguarding teams to monitor children who may be at risk of abuse. Senior nurses could access live information from both local and out-of-area health and social care services. Records that we looked at showed that it was checked for each child who attended to ensure that they had not been identified as at risk of abuse. Staff we spoke with described how they would use this system to identify whether children who attended the department were known to social services or may be at risk of abuse.

All clinical records for children contained a risk assessment tool aimed at quickly identifying any concerns regarding child welfare. These were completed correctly in the records that we reviewed.

An external health visitor attended the department weekly to review both the records of all children aged five years or less and any safeguarding referrals. The department had a designated safeguarding lead and staff told us that they saw them regularly for training and updates.

If staff had concerns regarding a patient's mental health, there was a protocol to follow to access a Mental Health Act (MHA) assessment through the mental health liaison team. If patients were distressed or became violent, security was called until the mental health liaison team arrived.

### **Cleanliness, infection control and hygiene**

Cleanliness and infection control policies were generally followed in the ED. There were effective systems in place to ensure that standards of cleanliness and hygiene were maintained. There had been improvements in hand hygiene since our November 2016 inspection.

Hand hygiene best practice was followed to prevent the spread of infection. We observed staff using antibacterial hand gel regularly and washing their hands before and after patient contact. The trust's infection prevention and control (IPC) team conducted monthly audits to monitor cleanliness and IPC compliance. Results from the last infection control audit (29 September 2017) found 100% compliance with hand hygiene policy. Hand washing facilities and sanitising gel were available in sufficient quantities in all clinical areas.

'Bare below the elbow' policies were adhered to, arms bare below the elbows is an IPC strategy to prevent transmission of infection from contaminated clothing and allows clinicians to thoroughly wash their hands and wrists. Staff wore minimal jewellery in line with the trust infection control policy. Personal protective equipment, such as gloves and disposable aprons were used in accordance with the trust's infection control policy.

The department was visibly clean and we saw support staff cleaning the department on a regular basis.

There was an isolation room for patients with suspected contagious diseases. It had its own ambulance entrance and negative pressure ventilation to help prevent the spread of infectious organisms.

Staff received up-to-date communication from the trust's infection prevention and control (IPC) team via the departmental IPC link practitioners. The IPC link practitioners were healthcare assistants and nurses whose roles included conducting monthly observational audits to monitor staff compliance with hand hygiene best practice. IPC link practitioners had also given a presentation at a recent induction for newly recruited nurses.

### **Environment and equipment**

The environment in the emergency department did not always enhance patient safety. Equipment, clinical waste and specimens were stored, labelled and handled appropriately throughout the ED.

The major treatment area, resuscitation room and children's treatment area were too small for the numbers of patients and staff who used them. This meant staff had to constantly move from one work space to another and that moving patients around the department was a slow and difficult process. Despite the care that staff took when moving patient trolleys, we saw numerous examples of minor collisions with work surfaces and large waste disposal bins because of a lack of space.

The paediatric area was secured by swipe-cards to prevent people inappropriately entering areas where children were seen. The paediatric treatment area had three cubicles large enough for a patient trolley and equipment for immediate assessment and treatment. It had a separate waiting area so that there was audio and visual separation of adults from children. There was a CCTV camera with view of the doors. The children's waiting area also had a separate door leading directly to the paediatric cubicles so that children could be brought into the department without having to go back through the adult area. However, there had been an increase in the number of children in the department following the centralisation of children's services at Worcestershire Royal Hospital, and the area was no longer large enough. This meant that children with minor injuries were treated in the minor treatment area and waited in the main waiting room with adult patients. Although paediatric patients would be seen in a separate cubicle, there was a risk that they could hear or see adult behaviour that was disturbing.

The paediatric treatment area did not have a computer for staff to use and did not have enough storage space for some of the documents that were needed. This meant that nursing staff often had to leave the treatment area to collect further supplies or to contact other members of staff. We entered the treatment area twice during our inspection to find no staff were present. Although children and families who were in treatment cubicles knew how to use their call bells, those in the waiting area did not know how to call for help if it was needed.

The department had a dedicated ambulance entrance, which was located near to the major treatment and resuscitation areas. A helipad was situated close to the ED to enable air ambulances to land. There was a helicopter landing policy to ensure the safe arrival and departure of patients and staff.

We checked a range of specialist equipment, including adult and children's resuscitation equipment. Resuscitation equipment was readily available and accessible throughout the

department. It was clean, clearly organised and well maintained. Areas were fully equipped, including size-appropriate equipment for children. Daily and monthly checks of all resuscitation equipment had been conducted. Consumables were rotated so that those approaching their expiry date were highlighted and used first.

Clinical waste and specimens were appropriately labelled and segregated. They were stored safely and disposed of according to hospital policy.

The layout of the ED supported patient flow to diagnostics. The diagnostic imaging department was directly adjacent to the ED, provided X-rays and ultrasound scans for walking patients and those on trolleys, so patients could be rapidly taken for x-rays and scans.

There was a process for reporting problems to the estates department but the response was not always helpful. For example, a recent risk assessment of the water supply indicated that most of the taps in the department needed to be opened on a regular basis to prevent the stagnation of water. There was no-one from the estates department to do this so the matron had to arrange for an ED healthcare assistant to do this instead. During our inspection one of the clinical fridges used for storing medicines stopped working and required replacement. Nursing staff followed the correct procedure and moved the medicines to a fridge in another part of the department. However, this meant they were not close to the patients that needed them. We were told that replacement fridges were available but the process for replacing them was lengthy and it would be several days before one was brought to the department.

There was a designated room for seeing patients who required a mental health assessment. This had been re-furnished since our April 2017 inspection so that it met the Psychiatric Liaison Accreditation Network (PLAN) quality standard requirements. PLAN standards include:

- Two doors which open outwards and are not lockable from the inside
- Obscured glass viewing panels to allow staff to observe from the outside whilst maintaining a degree of privacy for the patient
- A panic button or alarm system
- Furniture, fittings and equipment which are unlikely to be used to cause harm or injury to the patient or staff member
- No ligature points

Building works in the department meant that this room could not be used for two weeks. The temporary room that was used instead had been risk assessed by senior staff from the psychiatric liaison team. It was found to be safe if patients would not left on their own and were escorted in and out of the room. All the staff that we spoke with were aware of these precautions.

### **Assessing and responding to patient risk**

Patients were assessed within 15 minutes of arrival. However, the trust performance remained inconsistent for the number of patients arriving by ambulance who were kept waiting for over 60 minutes before being handed over to ED staff and was performing worse than the England average. This meant the ED was not consistently in line with the RCEM guidance.

When a patient self-presented to the department, receptionists logged their details and escalated to clinicians if a patient required urgent attention. Receptionists had written criteria that outlined 'red flags', such as chest pain, traumatic injury or signs of a stroke. They had an emergency call bell to use if a patient collapsed or in an emergency.

Patients who walked into the department, or who were brought by families or friends, reported to the reception desk. Once initial details had been recorded patients were asked to sit in the waiting room while they waited to be triaged by a nurse. We looked at the records of nine patients who had been triaged in the week prior to our inspection and found the assessments to be thorough

and effective. No patients had waited more than 13 minutes. Nurses told us they had completed specific training in triage and had been assessed as competent before undertaking the role. There were two triage nurses at busy times.

Trust figures showed from November 2016 to October 2017 the average waiting time to be triaged varied from 10 minutes to 12 minutes. A triage nurse told us that, if patients were waiting more than 10 minutes, they would look at the reason the patient was attending, their age, and when the injury or illness had first happened. They would then prioritise the patients who were most likely to need emergency treatment. Triage nurses could stream patients to the out of hours GP service that was located within the ED.

Patient early warning scores were used during triage and throughout the patient's treatment in the department. The National Early Warning Score (NEWS) was used for adults and a Paediatric Early Warning Score (PEWS) for children. This was a quick and systematic way of identifying patients who were at risk of deteriorating. Once a certain score was reached a clear escalation of treatment was commenced.

The ED matron monitored the completion of NEWS on a twice weekly basis. From 28 July 2017 to 22 September 2017 98% of NEWS had been correctly calculated and escalated appropriately. This had improved since our April 2017 inspection.

Staff used the NEWS to monitor and identify patient deterioration so that treatment can take place as quickly as possible. This included determining a patient's risk of sepsis (a life threatening infection of the blood). Suspected or confirmed cases of sepsis were managed using the Sepsis 6 care bundle. Sepsis 6 is a nationally recognised six-step care bundle that should be implemented within one hour. The steps are:

- Administering oxygen
- Taking blood cultures
- Giving intravenous (IV) antibiotics
- Giving IV fluids
- Taking lactate measurements
- Monitoring urine output

Regular audits of sepsis screening tool place and average results for the 12 weeks ending 20 October 2017, showed that 60% of patients with a NEWS of five had been screened for sepsis rather than 100%. However, during our inspection we observed two patients being rapidly screened for sepsis and receiving correct treatment (high levels of oxygen and intravenous antibiotics) with one hour.

From 28 July 2017 to 22 September 2017 calculation of PEWS varied from 75% to 100% and only 61% of high scores had been escalated to the appropriate staff member. In response to this the matron had allocated more senior staff to the children's treatment area. We could find no indication that children had come to harm as a result of high PEWS not being escalated.

We looked at seven sets of children's records where a PEWS would have been appropriate. All had been completed correctly and, where necessary, escalated to a senior decision maker.

Patient risk assessments had been completed correctly and in a timely manner. Risk assessments for nutrition and hydration, pressure ulcers, frailty and venous thromboembolism (blood clots) were consistently carried out and were acted upon when necessary.

Patients arriving by ambulance as a priority (blue light) call were taken immediately to the resuscitation room. Such calls were phoned through in advance so that an appropriate team could be alerted and prepared for the arrival of the patient. However, on the second morning of our inspection all four bays in the resuscitation room were full, as were all other treatment areas, with patients waiting on trolleys in the corridor. Although staff had identified one of the patients as well

enough to leave the resuscitation room, it was unclear where the new patient would have been treated if an emergency had arrived. Staff told us this was a frequent dilemma. We did have evidence of an incident where the resuscitation room being full had resulted in delays in patient care.

The department had developed a process called Senior Initial Assessment to safely prioritise all other patients arriving by ambulance. This was led by the Senior Initial Assessment Nurse (SIAN) assisted by a healthcare assistant. The SIAN staff received a clinical history from the ambulance crew, spoke briefly to the patients and then undertook clinical observations and initial investigations such as electrocardiograms. Once the assessment was complete a priority category was assigned to the patient, with category one being the highest priority. Doctors were informed immediately if patients were category one or two. This process of assessment and prioritisation is often known as triage. A second nurse was often required because there was not always room in a treatment area for patients to go to once they had been assessed. They therefore had to be monitored in the corridor until space became free.

Hospital figures showed that the average (median) waiting time for initial assessment of ambulance patients varied from seven to ten minutes from November 2016 to October 2017. This was within the limit of 15 minutes set by the Royal College of Emergency Medicine (RCEM Initial assessment of emergency department patients - 2017). We observed the SIAN process for extended periods throughout our inspection and found that waits were no longer than 12 minutes. Most assessments took place within eight minutes. We looked at 11 randomly selected records of ambulance patients who had arrived during the previous week and found that no-one had waited longer than 19 minutes. This had improved slightly since our April 2017 inspection when patients were waiting for up to 22 minutes.

If the department was crowded and several ambulances arrived in close succession there were not always enough nurses to look after newly arrived patients. When this happened, ambulance crews would stay with the patients after they had been triaged. This meant that they were not available to respond to other 999 calls.

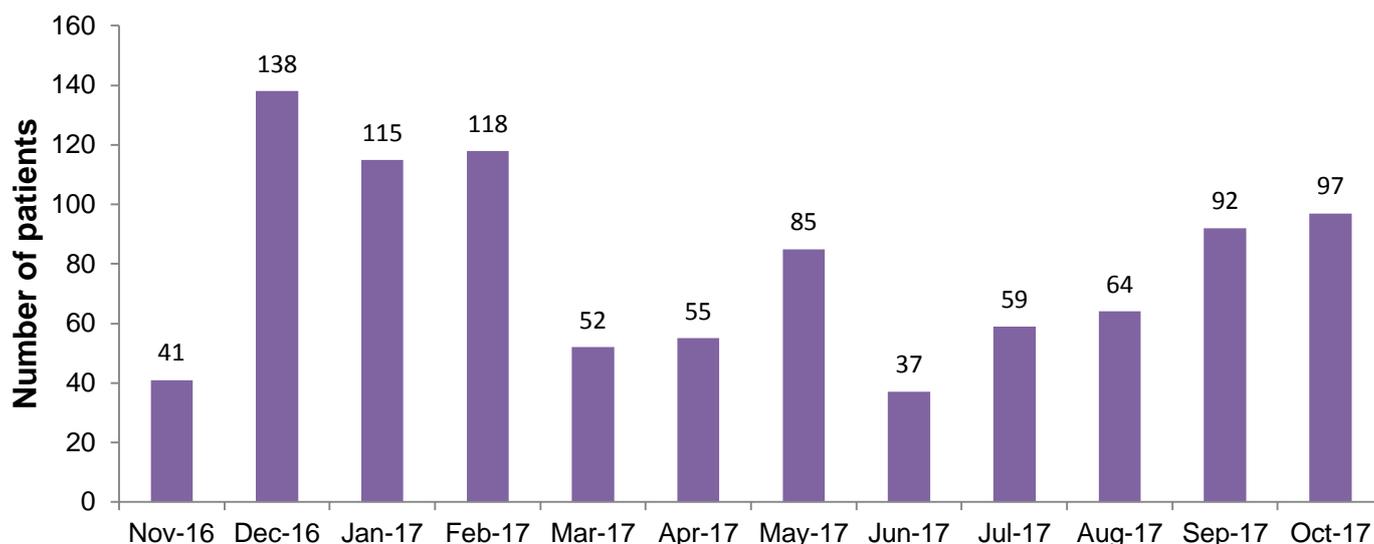
Delays in ambulance handovers had slightly improved. However, performance was not in line with RCEM recommendations that state ambulance handover should take no longer than 15 minutes. For the six weeks prior to this inspection, an average of 57% of patients had to wait for more than 30 minutes before being handed over to ED staff. This was an improvement since the inspection in April 2017 when 62% of patients waited over 30 minutes. During our inspection we did not see any ambulance crews having to look after their patients in the corridor.

The ambulance service recorded the number of patients who were kept waiting for over 60 minutes before being handed over to ED staff. If a patient is kept waiting under the care of the ambulance crew for one hour or more, this is known as a black breach. In the year ending October 2017 the number of black breaches had varied from 41 per month in November 2016, to 138 in December 2016. The latest data showed there were 96 black breaches in October 2017. The average for August to October 2017, was 84 per month.

Trust performance remained inconsistent for the number of patients who were kept waiting for over 60 minutes before being handed over to ED staff and was performing worse than the England average.

The graph below shows the number of patients per month who were kept waiting for over 60 minutes before being handed over to the ED staff.

## Number of black breaches



In order to reduce lengthy delays for ambulances, they were sometimes diverted to the Alexandra Hospital in Redditch. There was a protocol for ambulance crews to follow that involved contacting staff at the Alexandra Hospital ED prior to diverting, to establish how many extra ambulances they could accept. This process was followed during our inspection when GP referrals were diverted to this ED for a period of time. However, we also received comments from ambulance staff, who said that they did not want to be diverted to the Alexandra Hospital in Redditch as this would put them into the Birmingham ambulance catchment which they did not want to be in.

Routine use of the corridor to care for patients over long periods of time was previously highlighted as a major patient safety concern and continued. There were sometimes seven patients in the corridor waiting to be admitted to a ward. There was only space in the main corridor for four patients. This meant that additional patients were placed in part of the corridor that was round a corner and not in line of sight of nursing staff. Although these patients had received treatment and were in a stable condition, there was still a risk that their condition could deteriorate unexpectedly. This would not always be observed by staff. We asked to see data to show how long these patients spent in the corridor; however, the trust were unable to provide us with this. We therefore could not be assured that patients were not spending prolonged periods in the corridor upon arrival. We also could not be assured that the ED were monitoring the time these patients waited in the corridor.

Staff in the ED had recognised that there was increased risks associated with patients remaining in the department for more than six hours. In order to reduce the risk they had introduced the Global Risk Assessment Tool (GRAT). Nurses assessed and recorded whether each patient was in an appropriate clinical area, had experienced treatment delays, prolonged spinal immobilisation, delays in receiving food and drink or risks to pressure areas. If a risk was present the GRAT gave guidance regarding the action to take, including informing the nurse in charge and, where necessary, a senior doctor.

Records that we looked at included GRAT charts which appeared to have been completed correctly. Use of the GRAT reduced risks to patients and helped the nurse and doctor running the department to know which, and how many, patients were subject to risks associated with a crowded department.

Patients waited too long to see a specialist doctor after referral, with an average wait of two hours but a patient waited for six hours during the inspection. One of the reasons patients spent so long in the department was because they had been referred to a specialist doctor but one was not immediately available. The urgent care dashboard for October 2017 showed the average delay to see a specialist doctor was two hours. During our inspection one patient had waited for six hours. A number of adverse incidents had been recorded associated with delays in receiving a specialist

opinion and treatment. The trust had recently introduced internal professional standards, including maximum response times of one hour for specialist doctors. These had been implemented three weeks before our inspection. ED staff told us that some response times had improved.

Treatment areas were often full and so patients who had been treated, but needed to be admitted to a ward for further treatment, sometimes had to wait on a trolley in a corridor. Although patients had access to call bells, and there was access to resuscitation equipment in the corridor it was not designed as a clinical area and this increased risk to patient safety. In order to minimise this risk, no patients requiring oxygen or an intravenous infusion, or with a NEWS of four or more were cared for in the corridor.

The patient safety matrix often showed that the department was overwhelmed but it was not clear what action was taken as a result. During both inspections in November 2016 and April 2017, actions were not taken in response to the ED becoming 'overwhelmed'. The status of the ED was determined by a safety matrix that used information on patient numbers and complexity, ambulance arrivals and staffing levels to assess if the conditions promoted patient safety. The categories were normal, busy, critical and overwhelmed. However, there was no guidance or escalation criteria for staff to follow if the department became 'overwhelmed' or 'critical'.

At 2pm on the first day of our inspection the matrix showed that the department was "overwhelmed" due to large numbers of highly dependent patients in the department. The matrix did not contain guidance about what to do in these circumstances. We asked two experienced nurses about the actions they would take if the safety matrix confirmed that the department was overwhelmed. They had not been told that any action was expected and had been given the impression that the matrix was used for monitoring purposes only. We later asked a senior manager the same question. We were told that the safety matrix was displayed on computer screens accessible by senior managers throughout the hospital and that action would be taken but that ED staff may not be aware of it. This did not assure us that action would be taken.

From August to October 2017, trust data showed that safety levels in the department had been assessed as "critical" on 12 days; and the department had been assessed as "overwhelmed" on 77 days, or parts of days. Senior staff told us that this was an improvement since our April 2017 inspection but did not supply information to demonstrate the improvement.

A 'Surge and Escalation Management Protocol' had been developed which included actions for ED senior clinicians to take in response to each category on the safety matrix. However, it was unclear if the protocol had been implemented as the document was not dated and staff we spoke with were not sure if it had been introduced.

The status of the ED was reported to the bed management team every two hours via an electronic system. Bed management meetings took place four times per day and were attended by senior staff from across the hospital, including ED. We observed one of these meetings and saw staff worked together to review capacity and identify ways to improve flow and minimise the impact on patients in the ED.

Staff had access to 24/7 mental health support for patients of all ages. There was a mental health liaison team based in close proximity to the ED. The liaison team was staffed by the local mental health trust and was available from 8am to 10pm. Data from November 2016 to September 2017 showed the mental health liaison team responded within one hour to 98% of referrals.

Out of hours, staff contacted the mental health crisis team to provide assessments; however, referrals were not always responded to in a timely way. The crisis team worked across Worcestershire so response times varied depending on their capacity and workload. If there were concerns about a patient's safety they would receive 1:1 nursing until a specialist arrived.

There was a specific risk assessment for patients describing mental health problems. The assessment helped to determine whether there was a high, moderate or low risk associated with the mental health problem. Staff then contacted the mental health liaison team as appropriate. Patients who were deemed as low risk could be sent home, if medically appropriate and the

mental health liaison team would follow-up via telephone or invite them for a face-to-face assessment.

## **Nursing staffing**

Adult nurse staffing levels within the department meet national guidance. There were insufficient registered children's nurses in post to ensure that the emergency department had at least one registered children's nurse on duty per shift in line with national guidelines for safer staffing for children in emergency departments, however, there was a plan in place to resolve this by the end of November 2017.

There had been a staffing review in the last year using an evidence-based acuity tool (Baseline Emergency Staffing Tool). This calculated the number of nurses required by monitoring the number of patients that normally attended and the seriousness of their illnesses or injuries. In addition, nurse to patient ratios were checked against guidance issued by the National Institute for Health and Care Excellence (NICE). These calculations showed that 13 registered nurses were needed during the day and 12 at night. These numbers included one nurse to look after seven patients in the corridor.

We looked at nurse staffing for the month prior to our inspection and found that the planned number of nurses were on duty at all times. Not all of the nurses were employed by the trust. There were between one and four temporary staff on duty on most shifts. Some of these nurses came from the hospital's staffing bank and others from a temporary staffing agency. A senior nurse told us that most of the agency nurses worked regularly in the department and were familiar with local working practices. When a new temporary nurse arrived they were given an induction pack which briefly explained how the department worked. They discussed this with a permanent member of staff and signed to say that they had read and understood the pack.

In the November 2016 inspection, there were insufficient registered children's nurses in post to ensure that the emergency department had at least one registered children's nurse on duty per shift in line with national guidelines for safer staffing for children in emergency departments. Only one nurse was allocated for each shift to oversee the paediatric area. To mitigate risks where possible, 10 adult nursing staff had attended a course at the local university to complete to paediatric competencies.

In the trust October 2017 action plan update, the trust explained that the paediatric registered nurse establishment was 5.4 whole time equivalent (WTE), with a further 2.8WTE commenced in September 2017 making a total establishment of 8.2WTE. The Royal College of Nursing 2012 recommends a minimum of one paediatric registered nurse on shift, this was planned to be achieved by the end of November 2017 once the new staff have completed their induction and supernumerary period.

In this inspection, there was a named lead nurse for children within the ED. The lead nurse for children ensured that the nurse allocated to the children's area had completed specialist training in the care of sick children. The trust provided an on-call rota for a senior children's nurses to be available for advice if necessary. Until the new staff have completed their induction and supernumerary period, the trust had implemented mitigating risk actions. Each roster had a registered nurse with EPLS and safeguarding level 3 training. If a paediatric registered nurse is not rostered due to sickness/leave/training then a nurse with EPLS was allocated and paediatric assessment skills training. 11.96 WTE adult nurses had received EPLS and paediatric assessment skills training. Overall, nursing staff compliance with PILS was 76%.there was an education plan that ensured staff had the right skills to care for deteriorating patients less than 16 years and to safeguard welfare of children and young people 0 to 18 years.

Staffing levels were reported at the hospital-wide capacity management meetings four times a day. A staffing co-ordinator attended these meetings so that nursing staffing across the hospital could be reviewed and nurses could be flexed to other areas, where appropriate.

One of the executive directors came to the department to conduct weekly checks which included safe staffing levels. We were shown the results for week of 29 September 2017. Results showed that the safe staffing tool had been used and the nurse in charge felt confident that staffing levels were safe. The executive's weekly checks also included reviewing evidence to gain assurance that agency nursing staff on shift had received an induction and checking if staffing levels were displayed.

Analysis of staffing data for qualified nursing staff between the time period September 2016 to August 2017 identified there was a vacancy rate of 13% and a 12% turnover rate. The reported sickness rate was 3.3% (*Source: Routine Provider Information Request (RPIR)*). This was better than the national average of 5.1%.

### **Medical staffing**

Medical staffing was identified as a safety concern at previous inspections. There was insufficient medical cover to provide consultant presence in the department for 16 hours a day, as recommended by Royal College of Emergency Medicine (RCEM). Cover was for 15 hours a day.

Analysis of staffing data for Worcestershire Royal Hospital medical staff between the time period September 2016 to August 2017 identified there was an 11% vacancy rate and a turnover rate of 0%. The reported sickness rate was 0 to 1.4% for all sites (*Source: Routine Provider Information Request (RPIR)*).

The department employed 5.7 full time equivalent consultant doctors and there were two locum consultants. Their rota ensured a consultant presence from 8am until 11pm. The 7pm to 11pm shift was always filled by one of the locums.

Senior staff in the ED had recognised that medical staffing was a risk and were trying to recruit substantive consultants. The trust had been approved to recruit two more consultants to the urgent care division.

In addition to the locum consultants there were also two locum middle grade doctors. We were told that they had worked in the department for several months and were familiar with local working practices. They had received appropriate induction when they started.

We looked at the rota for the month before our inspection and saw that, when there were no consultants in the department, there was always a senior middle grade (ST4 or above) on duty. There was a consultant on-call from home at night. Staff told us that they appreciated the rapid, expert advice that this provided.

Junior doctors spoke positively about working in the ED. They told us that the consultants were supportive and always accessible. In-house teaching was well-organised and comprehensive. We observed one of the consultants teaching a junior doctor in the department following the arrival of a patient with a serious and unusual illness. Junior doctors told us their rota was well-organised and provided them with valuable experience balanced with sufficient rest days.

There was a named lead consultant for children within the ED. One of the permanent consultants had completed further training in the treatment of children in emergency settings. Medical staff compliance with European Paediatric Advance Life Support (EPLS) was 100%. Records showed that there was always a doctor on duty who had qualified in EPLS. Many of the consultants were instructors on paediatric resuscitation training courses.

We saw consultants working clinically in the department. They led the treatment of the sickest patients, advised more junior doctors and ensured a structured clinical handover of patient's treatment when shifts changed.

## **Records**

Staff kept appropriate records of patients' care and treatment. We reviewed 25 patients' records and found they were generally clear, up-to-date and available to all staff providing care. ED staff noted the date and time that they completed their entry and some used name stamps that clearly printed their name. However, three entries from specialist doctors visiting the department did not include all of these details. This meant it could be difficult to establish which staff member had completed that episode of care.

Standards of record-keeping had improved since our April 2017 inspection.

Patients' details were recorded on a computer system when they arrived so that staff could monitor how long they had been waiting and the assessments they had received. This system could be accessed by all ED staff. The computer system was used to generate paper records once a patient registered so that staff could record the care and treatment given. For patients who arrived by ambulance, paper copies of their ambulance notes and handover were incorporated into their ED records.

Patient records and information stored on computer was protected by passwords and backed-up to keep it secure. The system produced patient records in a paper format so that staff could record care and treatment given.

When patients were admitted to a ward, or referred to a clinic, their ED records were scanned into the hospital electronic records system so that ward staff could view them. This included mental health assessments if necessary. Once patients left the ED, their paper records were scanned onto the computer system and discharge summaries were sent to patients' GPs electronically. Paper records were then securely shredded.

When not in use, paper documents were held in storage racks which were supervised at all times. When patients left the department the paper record was scanned on to the computer system to allow access to records for patients who had previously attended the department. Paper records were disposed of using a secure shredding service that ensured patient information was kept safe. Risk assessments were completed appropriately in most of the records we reviewed including assessment of patient risks, such as pressure ulcers, infection, allergies and falls. Clinical observations, nursing care, advice and medication were all accurately recorded. This had improved since our April 2017 inspection when records did not support timely risk assessments and they were sometimes not carried out.

All records we reviewed contained information on patient's physical, mental and social needs. The mental health liaison team completed assessments that included patients' biological, psychological and social factors. After an assessment, they developed an individualised care plan for the patient. The care plan was incorporated into the patient's ED notes so that ED staff had access.

## **Medicines**

Staff prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right time.

There had been improvements in the administration of medicines. At our April 2017 inspection we had found that time critical medicines (TCM), including those for the treatment of sepsis, were not always administered. TCM are groups of medicines where delayed administration can result in

slower recovery, serious harm or death. Further training had been developed and incorporated into the induction, mandatory and junior doctor training. We also saw examples where the pharmacy team had highlighted TCM onto patients' medicine charts in order to avoid missed or delayed doses. We saw no patients wait for TCMs during our inspection.

Medicines were stored securely within locked rooms and cupboards with access restricted to authorised staff. Overall improvements in monitoring and checking medicine room and refrigerator temperatures were seen. The implementation of a new temperature recording form supported staff to ensure that medicines were stored safely and provided information on what action to take if the temperatures were not safe for medicine storage.

Resuscitation trolleys containing medicines and equipment required in an emergency were accessible. The trolleys were all safely secured with tamper proof seals. Checks were in place to ensure emergency medicines were available and safe to be used.

Members of the pharmacy team undertook medicine reconciliation to ensure patients medicines were available as well as checking for safe prescribing. Any known allergies or sensitivities to medicines were recorded on medicine charts. This information is important to prevent the potential of a medicine being given in error and causing harm.

A seven day clinical pharmacy service had been commenced. This service was now fully embedded and part of the ED team. Members of the pharmacy team included four pharmacists and two pharmacist technicians. In particular the team focussed on patients who had been prescribed time critical medicines. For example, Parkinson's disease medicines, anticoagulants and insulin and ensured that there were no missed doses.

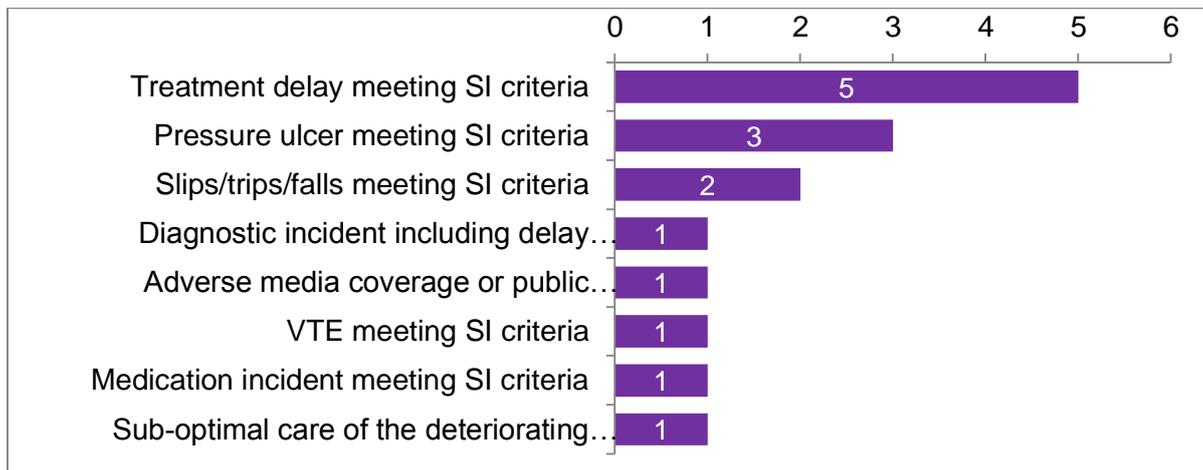
## **Incidents**

The department generally managed patient safety incidents well. There was a culture of incident reporting in the department. All staff we spoke with knew how to report incidents and what should be reported. They received feedback when an incident had been reported or following investigation. Incidents and complaints were discussed at the daily safety brief that was included in the staff handover.

In accordance with the Serious Incident Framework 2015, the trust reported 15 serious incidents in the ED that met the reporting criteria set by NHS England, from December 2016 to November 2017. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. However, the initial descriptions on the incident log indicated that four of the serious incidents happened elsewhere in the hospital, although the patients had been admitted via the emergency department. Incorrect allocation of serious incidents means that opportunities for preventing similar incidents may be lost.

Treatment delay and pressure ulcers were the most common category reported, five and three reported, respectively. One of the incidents pertaining to treatment delay resulted in patient death following failure to act on abnormal blood test results. The root cause analysis concluded that the outcome was unlikely to have been significantly different if the patient had received the initial dose of intravenous antibiotics earlier. Two of the three pressure ulcers were confirmed as taking place in the AE department and were due to extended periods without being repositioned.

The breakdown by serious incident type at Worcestershire Royal Hospital's ED was as follows:



We looked at root cause analysis reports for four of the serious incidents. Although the reports followed the NHS Serious Incident Framework by an independent member of trust staff, the investigations were inconsistent and some aspects were omitted. For example, terms of reference were not always completed and were not always reflected in the findings of the investigation; organisational factors were not considered, even when they were significant; lack of NEWS escalation was not fully investigated; there was no mention of support for staff involved in the incident and there were no plans to audit the action plans to ensure that they were effective. The investigations were not completed in the 60 days set out by the NHS Serious Incident Framework.

The trust had recently created a serious incident review group that monitored the progress and quality of investigation reports and action plans. They had recently introduced a “round table” technique which brought together the majority of staff involved in the incident. This allowed the interaction of different disciplines to be discussed and strengthened the action plan which resulted.

Managers investigated incidents and shared lessons learned with the whole team and the wider service. Learning from incidents was discussed with all staff during safety briefings which were included in twice daily handover sessions.

Quarterly data was produced for all incidents and this was shared across the organisation. Individual areas were able to use the data to understand what was happening across the trust and be able to take action in their own areas if necessary.

From November 2016 to October 2017, there were no reported incidents that classified as never events in the ED. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death, but neither need have happened for an incident to be a never event. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.

Monthly mortality and morbidity meetings took place and were well attended by medical and nursing staff. We were told that primary reviews of all deaths in the ED had taken place and secondary reviews were carried out when appropriate. The trust provided us with a flow chart describing the primary and secondary mortality review process dated July 2017, however, it had ‘medicine’ within the title, so we were unclear if this process mirrored within urgent and emergency care. Whilst the notes of the meeting contained actions it was not clear how these would be taken forward or reviewed.

Duty of candour was followed in the ED. Staff could describe their responsibilities and we saw evidence that they informed patients when things went wrong. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. New employees of the trust attended an awareness

of duty of candour training module during their induction training. Directorate management teams were trained in awareness of the duty of candour requirements.

### **Safety thermometer**

The NHS Safety Thermometer is a national tool used to record the prevalence of patient harm. It provides information for staff to monitor their performance in delivering 'harm-free care'. Measurement is intended to focus attention on reducing patient harm.

Data collection takes place one day each month – a suggested date for data collection is given but departments can change this. Data must be submitted within 10 days of suggested data collection date. The ED submitted data from the five-bedded emergency decision unit.

Patients rarely spend more than 24 hours in emergency departments; therefore the safety thermometer is not routinely used.

## **Is the service effective?**

### **Evidence-based care and treatment**

The emergency department (ED) provided care and treatment that was based on national guidance. This included National Institute for Health and Care Excellence (NICE) and the Royal College of Emergency Medicine (RCEM) standards. Managers checked to make sure staff followed guidance. Clinical pathways were in place for serious conditions, such as heart attacks and strokes. Staff were aware of pathways to follow and could demonstrate how to access this information.

There was an audit programme that monitored the implementation of guidance from national clinical organisations. Action plans were put in place if any shortcomings were discovered.

The audit programme included audits of NICE guidance, such as sepsis in adults and meningitis in children. The department also took part in national benchmarking clinical audits including national annual RCEM audits.

Staff were aware of current NICE guidance, such as NICE NG10 - Violence and aggression: short-term management in mental health, health and community settings, NICE CG42 - Dementia: supporting people with dementia and their carers in health and social care and NICE CG90 - Depression in adults: recognition and management. Training had been provided to staff and they were familiar with principles included in the guidance. For example, patients who were thought to be experiencing depression were referred for a mental health assessment.

There was a departmental audit programme that monitored the implementation of NICE guidance, such as treatment of fractures. Prescribing of medicines for cardiac conditions was also monitored. Following audits action plans were put in place if any shortcomings were discovered. For example, the treatment of certain heart conditions had recently been updated.

The ED completed audits to monitor compliance with the NICE guideline NG51 Sepsis: recognition, diagnosis and early management. This included monitoring compliance with sepsis screening and use of the Sepsis 6 care bundle. Results showed the department had screened 60% of patients with a NEWS of five had been screened for sepsis rather than 100%, for the 12 weeks ending 20 October 2017. However, during our inspection we observed two patients being rapidly screened for sepsis and receiving correct treatment (high levels of oxygen and intravenous antibiotics) with one hour.

Work was ongoing to improve compliance with sepsis management, in line with NICE NG51. For example, the ED sepsis lead nurse had introduced a red tray system where patients' notes were placed if they were suspected to have sepsis. The red tray was on the nursing station, which was

highly visible to medical and nursing staff. This meant all staff could clearly and quickly see if any patients in the department were suspected to have sepsis, to prioritise and implement Sepsis 6 within one hour. This concern was also discussed with staff at the twice daily safety briefings that we observed during our inspection.

Patients were assessed using evidence-based tools, such as the National Early Warning Score (NEWS), Paediatric Early Warning Score (PEWS). The ED matron monitored the completion of NEWS on a twice weekly basis. From 28 July 2017 to 22 September 2017 98% of NEWS had been correctly calculated and escalated appropriately. This had improved since our April 2017 inspection. For the same period, calculation of PEWS varied from 75% to 100% and only 61% of high scores had been escalated to the appropriate staff member. In response to this the matron had allocated more senior staff to the children's treatment area. We could find no indication that children had come to harm as a result of high PEWS not being escalated. We looked at seven sets of children's records where a PEWS would have been appropriate. All had been completed correctly and, where necessary, escalated to a senior decision maker.

The twice weekly nursing audits also looked at 13 other aspects of nursing care, including the confidentiality of patient records, the readiness of resuscitation equipment and assessment of pressure areas. 12 of the 13 criteria had scores above the trust target of 90% over the previous three months ending 27 October 2017. The exception was documentation of peripheral vascular devices which had an average compliance of 52%.

Mental health assessments, interventions and treatments offered were in line with NICE guidance. Patients who were suspected to be experiencing depression were referred to the mental health liaison team. Patients who were considered to have low-risk mental health symptoms who were unwilling or unable to see the mental health liaison team during their attendance were followed up the next day.

## **Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs whilst in the ED. Staff made adjustments for patients' religious, cultural and other needs.

Nursing staff conducted care and comfort rounds that included offering patients food and drink. All patient records we reviewed showed rounds were completed every two hours and food and drinks consumed were documented. This was an improvement since November 2016, when rounds were not consistently being completed every two hours.

Following the assessment of a patient, intravenous fluids were prescribed, administered and recorded when clinically indicated.

There was a drinks dispenser in the major's area for patients and visitors to use. Although friends and relatives were directed to catering facilities during the day. However, it was difficult for relatives to find food during the night, there were none open at night apart from a drinks vending machine. We observed the relative of a patient who had been in the department for ten hours asking a receptionist about food. The relative said "We have been here all night. Is there anywhere that I can get some breakfast?" The receptionist gave helpful advice about the facilities that were available that morning.

## **Pain relief**

Administration of pain relief had improved since our April 2017 inspection. Effective pain relief was given in a timely manner and its effects were monitored.

Staff monitored patients' pain regularly and used tools to assess pain in patients with communication issues, such as patients who were unable to speak or those with dementia. Pain was included in the two-hourly nursing care and comfort rounds.

Effective pain relief was given in a timely manner and its effects were monitored. Patient records showed that patients' pain levels were assessed and recorded using pain scores. We observed nursing staff administering rapid pain relief when they assessed patients who had walked into the department and those who had arrived by ambulance.

Children were offered appropriate and prompt analgesia, in line with RCEM Management of pain in children. The results of the pain relief were monitored in accordance with the RCEM Management of Pain in Children guidance.

Throughout the inspection, we observed staff asking patients if they were in any pain and providing analgesia in a timely way, where required. Nurses were able to administer simple pain relief under a patient group direction, which permitted suitably trained staff to supply prescription-only medicines to groups of patients, without individual prescriptions.

### Patient outcomes

The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

The department took part in national clinical audits to monitor patient outcomes and benchmark their service against others. Results were varied. Although there were areas where the ED performed similar to the national average, results generally did not meet national standards, except for the RCEM Severe Sepsis and Septic Shock Audit for 2016/17, where the ED met the national standard in seven of the 13 measures.

The results for the 2016/17 RCEM audits are shown below.

#### RCEM Moderate and acute severe asthma audit

The ED did not meet 14 of the 15 national standards in the RCEM audit of moderate and acute severe asthma in 2016/17. However, they performed in the highest 25% of trusts in 12 of the standards measured. Results are shown in the table below, in green where the ED performed in the highest 25% of departments, yellow where they were similar to other departments and red where they performed in the lowest 25% of departments.

Seven of the measures were defined as fundamental standards, which meant RCEM recommends the trust should put in place for all patients (national standard 100%).

Standard	Standard requirements	This ED	National Standard
Standard 1a	Oxygen given on arrival to maintain sats 94-98%	18%	100%
Standard 1b	Oxygen prescribed on arrival to maintain sats 94-98%	24%	80%
Standard 2a	Vital signs measured and recorded on arrival at the ED	56%	100%
Standard 2b	Patients with abnormal vital signs have a further set of vital signs recorded within 60 minutes	26%	80%

Standard 3	High dose nebulised $\beta_2$ agonist bronchodilator given within 10 minutes of arrival	10%	100%
Standard 4	Add nebulised ipratropium bromide if there is a poor response to nebulised bronchodilator therapy	93%	100%
Standard 5a	Steroids given within 60 minutes of arrival (acute severe)	39%	100%
Standard 5b	Steroids given within 4 hours (moderate)	48%	100%
Standard 6	Intravenous magnesium given to adults with acute severe asthma who do not respond well to bronchodilators	86%	80%
Standard 7	Evidence of consideration given to psychosocial factors in adults prior to discharge	33%	50%
Standard 8a	Evidence of assessment before discharge that the patient's inhaler technique is satisfactory	21%	80%
Standard 8b	Evidence of assessment before discharge that the patient's inhaler type is satisfactory	63%	80%
Standard 9	Discharged patients have oral prednisolone prescribed	76%	100%
Standard 10	Written discharge advice given to the patient	32%	80%
Standard 11	GP or clinic follow-up arranged according to local policy for discharged patients within 2 working days	11%	80%

#### RCEM Consultant sign off audit 2016/17

The ED did not meet any of the national standards in the RCEM consultant sign-off audit in 2016/17. This audit monitored the percentage of patients from certain higher-risk groups who had a senior medical sign-off prior to admission, transfer or discharge, in line with guidance.

The audit results for consultant sign off are shown in the table below. Red indicates where they performed worse than other departments.

Standard	Patient group	This ED	National standard
Standard 1	Patients aged 30 years and over with chest pain	0%	100%
Standard 2	Children aged under one year old with fever	0%	100%
Standard 3	Patients making an unplanned return to ED for the same condition within 72 hours	0%	100%
Standard 4	Patients aged 70 years and over with abdominal pain	0%	100%

The ED also not meet any of the national standards for senior doctor (non-consultant) sign off for these groups of patients. They performed similar to other departments for senior doctor sign off for

children aged under one year old with fever, but were worse than other departments for senior doctor sign off for the other patient groups.

### RCEM Severe Sepsis and Septic Shock Audit 2016/17

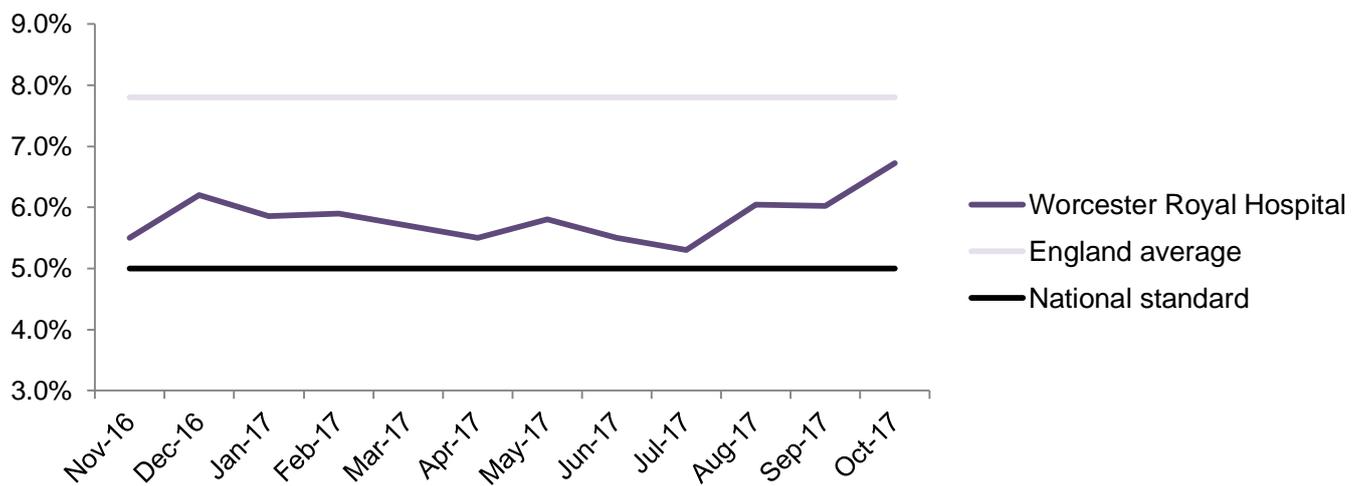
In the RCEM Severe Sepsis and Septic Shock Audit for 2016/17, the ED met the national standard in seven of the 13 measures. Performance was similar to or better than other trusts in each measure. The standards where the ED performed better than most other trusts were:

- Standard 2: Review by a senior ED doctor or involvement of critical care before leaving the ED
- Standard 3a: Oxygen given to 50% of patients within one hour of arrival
- Standard 3b: Oxygen given to all patients within four hours of arrival
- Standard 4a: Serum lactate measured within one hour of arrival for 50% of patients
- Standard 4b: Serum lactate measured within one hour of arrival for 100% of patients
- Standard 5a: Blood cultures obtained within one hour of arrival for 50% of patients
- Standard 5b: Blood cultures obtained within one hour of arrival for 100% of patients
- Standard 6a: Intravenous fluids given within one hour of arrival for 75% of patients
- Standard 6b: Intravenous fluids given within four hours of arrival for all patients
- Standard 7a: Antibiotics administered within one hour of arrival for 50% of patients
- Standard 7b: Antibiotics administered within one hour of arrival for 100% of patients
- Standard 8: Urine output measurement or fluid balance chart implemented within four hours of arrival

### Unplanned re-attendance rate within seven days

The rate of patients re-attending the ED did not meet the national standard. Re-attendance rate within seven days for the same condition is used as an indicator of patient outcomes and the Department of Health states this should be no more than 5% of patients. From November 2016 to October 2017, unplanned re-attendance within seven days had varied between 5.5% and 6.7%. Although this did not meet the national standard, the ED performed better than the England average for this period, which was 7.8%. It was also an improvement on re-attendance rates at our April 2017 inspection.

The table below shows the ED performance compared to the national standard and the England average performance over this time period.



(Source: NHS Digital - A&E Quality Indicators)

### Competent staff

The department made sure nursing staff were competent for their roles. All nursing staff had received an appraisal in the last year. Nurses new to the department received a three or four day induction programme, depending on their previous experience. They then worked on a supernumerary basis for one month. The matron showed us the structured competency framework used in the department for nurses. It covered all skill levels from a nurse with no previous experience of emergency nursing to those at senior sister level. It was known as the “Five Year Plan” and was based on evidence from the Emergency Nurses Association. It had recently been updated so that it reflected the Royal College of Nursing’s National Curriculum and Competency Framework for Emergency Nursing published in July 2017. The competency framework was used by nurses and their managers to help identify when they were ready for increased levels of responsibility.

Newly qualified nurses were placed on a preceptor programme. Preceptorship is a period of structured transition for newly qualified healthcare professionals lasting up to one year, during which support is given by a preceptor who provides supervision, mentoring and support to develop confidence and refine skills. The newly qualified nurses we spoke with felt their preceptorship had met their learning needs and gave examples of competencies gained.

Appraisal rates for nursing staff had improved. Records showed that all ED nurses had received an appraisal in the last year. Nurses told us that there was protected learning time in order to respond to their training needs and that there were regular group supervision sessions. We spoke with junior doctors who were complimentary about their training programme. They told us that they received regular supervision from the ED consultants, as well as weekly teaching sessions.

The majority of medical staff in the ED received annual appraisals to review their performance and clinical competence. 85% of medical staff eligible for an appraisal had received one and the remaining 15% of staff were new starters that were due to complete their preceptorship programmes. The trust target was 90% compliance. Senior doctors told us that appraisal were now carried out more frequently.

In November 2016, the trust also did not provide evidence to show medical staff in the ED had been revalidated to practice by the General Medical Council (GMC). This meant we could not be assured that doctors met the GMC professional standards. During this inspection, the trust provided evidence to show doctors working in the ED had undergone revalidation with the GMC

within the previous five years. The information provided by the trust showed they were monitoring medical staff revalidation and those who were approaching the date for renewal were highlighted. Staff that we spoke with were aware of the trust policy for sepsis management and told us that they had received training within the last year. The clinical team leader for the psychiatric liaison service provide training to ED doctors and nurses in mental health conditions. This helped them to be able to identify and manage issues such as deliberate self-harm, learning disability and autism and dementia.

### **Multidisciplinary working**

The multidisciplinary team worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Staff spoke of good working arrangements with other departments including oncology, children's services, diagnostic services and critical care. There was an X-ray service adjacent to the department, and we saw effective working arrangements that benefitted patients.

There was a GP from an external provider working within the ED. Staff told us that they had good working relationships with the GP and they were able to provide care to patients who presented with minor illnesses. Nurses rotated between the children's ward and the ED in order to share best practice and to improve working relationships.

There were care pathways to follow if patients needed admission to the hospital, for example, following a stroke or a fractured neck of femur (broken hip). Staff were familiar with these and made appropriate referrals.

We observed ED staff working seamlessly with ambulance staff and with mental health teams in order to improve the care of patients. There were established links with trust's learning disability team and the frailty team at the neighbouring Alexandra Hospital. This helped to ensure safe discharge arrangements for patients with complex needs.

### **Seven-day services**

ED consultants provided cover 24 hours per day, 7 days per week, either directly within the department or on-call.

Patients could access diagnostic imaging services at all times, in line with the NHS Services Seven Days a Week Priority Clinical Standards. The department had access to radiology support 24 hours each day, with rapid access to computerised tomography (CT) scanning when indicated. There was always a senior radiology doctor available within in the hospital. However, the stroke service was not available at night. This meant that a general physician had to administer rapid thrombolysis ("clot-busting" infusions) to patients diagnosed with a stroke.

The frailty assessment unit at the neighbouring Alexandra Hospital, whilst much admired and appreciated by ED staff, was only open from 9am to 5pm, Monday to Friday. ED staff told us that many frail and elderly patients attended the department at week-ends and did not receive the specialist care and treatment that happened during the week.

A seven day clinical pharmacy service operated in the ED. Since the April 2017 inspection this service was fully embedded and part of the ED team. Members of the pharmacy team included four pharmacists and two pharmacist technicians. There was an on-call pharmacy service outside of normal working hours.

### **Health promotion**

Staff took the opportunity, if it arose and was appropriate, to discuss smoking cessation, weight reduction, and drug and alcohol misuse with patients. We observed a doctor advising a patient about techniques for stopping smoking in order to improve a lung condition. There were leaflets and contact details of relevant organisations that may be able to offer support and advice to patients.

### **Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. The staff we spoke with had sound knowledge about consent and mental capacity. 92% of clinical staff had received yearly training about mental capacity issues including training about the Mental Capacity Act 2005. When patients lacked the capacity to make decisions for themselves, such as those who were unconscious, we observed staff making decisions which were considered to be in the best interest of the patient. We found that any decisions made were appropriately recorded within the medical records.

We observed that consent was obtained for any procedures undertaken by the staff. This included both written and verbal consent. Consent forms were available for people with parental responsibility to consent on behalf of children. The staff that we spoke with had a good working knowledge of the guidance for gaining valid informed consent from a child. They were aware of the legal guidelines which meant children under the age of 16 were able to give their own consent if they demonstrated sufficient maturity and intelligence to do so (Gillick competency). Otherwise, consent would be sought from the child's parent or guardian. If a child attended without a person who was able to provide consent, staff would attempt to contact an appropriate adult.

Staff reported that restraint was not used in the department and that physical violence was uncommon. If physical violence occurred, security and/or the police would be contacted.

## **Is the service caring?**

### **Compassionate care**

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. During our inspection we saw many examples of patients treated with compassion, dignity and respect. Emergency department (ED) staff introduced themselves by name and explained treatment plans in terms that were easily understood. Many staff expressed compassion for patients spending excessive time on trolleys in corridors. One senior member of ED staff told us they found it very difficult, when they were arriving in the morning "to look patients in the eye when I had said goodbye to them in the same corridor the night before."

We spoke with 11 patients and two family members. Most of them had been in the department for many hours but they frequently mentioned the kindness of the staff. One patient said "I have been impressed by the efficiency and friendliness of all the staff".

Patients with dementia and/or a learning difficulty were given special consideration. Conversations were held at a pace that suited the individual and simple terms were used to help patients understand what was happening. A nurse told us about a patient with a learning difficulty who had arrived the previous day. They had initially been distressed by the strange surroundings of the ED and so had been treated as a priority in order to minimise their distress. A parent stayed with the patient throughout their stay and, after treatment, they were able to go home.

A patient with dementia, who was waiting to be admitted to a ward, was moved from the corridor to a quieter area of the department. This helped the patient to be less agitated. The patient told us “I am very happy here”.

There was no privacy and little confidentiality for patients waiting on trolleys in the corridor. ED staff were frustrated about this situation and were as discrete and considerate as possible. Patients were moved to a more private cubicle when intimate care was needed. Staff had considered introducing privacy screens but this made it impossible to observe all the patients in the corridor, thus reducing safety. Nurses and doctors frequently apologised for the crowded department. We observed patients being moved temporarily to a curtained cubicle if they required urgent personal care, such as an electrocardiogram or bedpan. Confidentiality was provided to patients at reception by means of signs asking people to stand at a distance from the reception desk. Receptionists were cheerful and welcoming and took trouble to inform and reassure patients and their families.

Volunteers worked in the department and provided company for patients who were waiting on their own. We observed them talking gently to older people and with humour to younger people.

We heard staff updating relatives about patients' progress whilst maintaining confidentiality. Communication with children was well thought out, age appropriate and effective. We observed a nurse holding the hand of a distressed patient while they explained what was happening and how they were going to try to make things better.

Feedback from patients during this inspection confirmed that staff treated them well and with kindness; however, the ED did not routinely gather feedback so there was limited information from patients for the 12 months prior to this inspection. The department participated in the national Friends and Family Test (FFT), but response rates were below 1% from April to September 2017, compared to the England average of 13%. FFT is a tool that supports people who use NHS services to provide feedback on their experience. It asks people if they would recommend the services they have used. Results from April to September 2017 were variable compared to the national average, but it was difficult to draw conclusions from the data, as the small sample size may not be representative. In August 2017, no patients completed an FFT.

### **Emotional support**

Staff provided emotional support to patients to minimise their distress.

We observed staff giving emotional support to patients and their families. They gave open and honest answers to questions and provided as much reassurance as possible. One doctor put an arm around the shoulders of a patient who was trying to walk in order to give them confidence.

Support was particularly strong for relatives of patients who needed to be in the resuscitation room. We observed nursing staff preparing relatives before they entered the resuscitation room and then carefully explaining what had happened and the details of the immediate treatment plan.

There was a quiet sitting room where distressed relatives could sit in a private space. This was large enough to accommodate several people and was appropriately equipped. We observed staff making frequent visits to the room to make sure that relatives were comfortable.

Multi-faith chaplaincy services were available day and night for people who would benefit from spiritual support.

### **Understanding and involvement of patients and those close to them**

Staff involved patients and those close to them in decisions about their care and treatment.

Patients and their families told us they were kept informed of all care and treatment due to be carried out. Staff were praised for the quality of the communications to families so that they understood the sequence of events and the likely timings around these.

The parent of one of the children in the department told us that the complexities of looking after small children had always been taken into account when their family had been treated in the emergency department. A patient who was waiting for an X-ray told us “They have explained what is going on and have given me painkillers. They have all been very polite and helpful”.

We spoke with two patients as they left the unit. They had all been given advice about what to do when they were at home. One had been given information leaflets to reinforce the verbal advice.

## Is the service responsive?

### Service planning and delivery to meet the needs of local people

The trust was undertaking significant work to develop services to meet the needs of local people, however patients could not currently access the service in a timely manner.

There had been a significant amount of service planning since our April 2017 inspection. It was focussed on improving patient flow through the emergency department (ED), thus preventing patients waiting in corridors. Ultimately the aim was for patients to spend no more than four hours in the department.

A new frailty assessment unit had opened at the neighbouring Alexandra Hospital two weeks prior to our inspection. The trust had worked with the ambulance service and local GPs to agree that all patients over 75 years with conditions associated with frailty would be taken to the Alexandra Hospital. The arrangement appeared to be working well and ED staff told us that the number of very frail patients waiting for admission to a ward had reduced significantly. The local ambulance service referred appropriate patients directly to the FAU during its opening hours from 8am to 8pm on weekdays, therefore preventing the need for an ED attendance at both EDs.

The ambulatory emergency care (AEC) unit was being rebuilt in order to expand capacity to 16 patients. Calculations indicated that this would avoid an additional 15 admissions a day as patient could be treated as day cases in the unit.

To meet the needs of local people when Worcestershire Royal Hospital ED was full, ambulances were diverted to the Alexandra Hospital ED. There was a protocol for ambulance crews to follow that involved contacting staff at the Alexandra Hospital ED prior to diverting, to establish how many extra ambulances they could accept. This process was followed during our inspection when all patients referred by their GP to Worcestershire Royal Hospital were diverted to the Alexandra Hospital ED. This reduced the attendance at Worcestershire Royal Hospital. However, we also received comments from ambulance staff, who said that they did not want to be diverted to the Alexandra Hospital in Redditch as this would put them into the Birmingham ambulance catchment which they did not want to be in. There were no occasions during this inspection where all ambulances were being diverted to this ED; however, staff told us that this had happened over the weekend of our visit.

A new winter plan had been agreed by the trust board on 14 September 2017. It described how the trust would ensure safe patient flow through the ED and wider hospital setting during the winter when there was usually peak demand was for hospital admissions. It included an enhanced primary care service adjacent to the emergency department, introducing a seven day a week service in the AEC unit, direct communication between GPs and hospital consultants, opening a palliative care ward and increasing bed capacity in other specialties. It also included practical measures, such as a discharge lounge large enough to take beds or trolleys and moving operating

theatres maintenance to the weekends when fewer theatres were used. However, the last two measures had no costs calculated and so it was not clear when, or if, they would take place.

Most of the projects in the plan had been well researched and had proven to be effective at other hospitals except for the method of “streaming” ED patients to the enhanced primary care facility. The winter plan described this being done by a primary healthcare professional but the Royal College of Emergency Medicine states that streaming should be done by an experienced ED clinician. (RCEM Initial Assessment of Emergency Department Patients February 2017).

### **Meeting people’s individual needs**

Improvements had been made since our April 2017 inspection to try to meet patient’s individual needs, however, the individual needs of patients waiting in the corridor on trolleys were still not fully addressed. Despite this, reasonable adjustments had been made for patients with dementia, a learning disability, gender and cultural needs.

During the previous inspections, patients were not always cared for in an environment that met their individual needs; for example, in the corridor. As part of the Section 29A Warning Notice issued in January 2017, the trust was required to take action to significantly improve so that patients were not being routinely cared for in the corridor due to poor flow through the ED. However, when we re-inspected in April 2017, we found patients were still frequently being cared for in the corridor and another Warning Notice was issued.

At this inspection, we observed patients still being treated in the corridor. Most patients were in the corridor because they needed to be admitted to a ward but there were no empty beds available for them. We observed patients in the corridor for up to 12 hours. This meant routine nursing observations, conversations about care and eating of meals were undertaken in a public space with other patients and relatives passing by to the X-ray department. Despite this, patients told us that they felt safe and appreciated the attention that they received from nursing staff. However, they also felt exposed in the busy corridor and were unable to rest. One patient, who had spent the night in the corridor said “It was like trying to sleep on the M1 motorway. Impossible.”

Since our April 2017 inspection additional nursing staff had been allocated to care for and monitor patients in the corridor. We observed them assisting patients to eat and ensuring that they had enough to drink.

The service prioritised distressed patients so they were seen quickly following triage. We observed patients with mental health conditions being seen promptly during this inspection. Where appropriate, staff would refer patients to the mental health liaison team prior to the end of their medical treatment to prevent delays in the patient being discharged.

Staff accessed support and advice from the hospital’s dementia lead nurse and learning disability nurse. Flower symbols were displayed in cubicles of patients living with dementia to make it clear to staff that a patient may have additional needs. Staff told us that lead nurses had provided teaching sessions and communication groups to educate them on caring for patients living with dementia or a learning disability.

Nurses and junior doctors had received training in the care of patients with a learning disability. They were able to speak confidently about the differing needs of patients with a learning disability and prioritised their care where possible. The majority of staff had recently undertaken training in the specific needs of patients living with dementia. All patients over the age of 65 were assessed for signs of dementia and frailty. If they were found to be vulnerable they were referred to a specialist team. We were told that patients with complex needs would be treated by a senior doctor who had the experience necessary to meet their requirements.

Staff referred patients to the trust’s patient flow centre (PFC) and rapid response team prior to discharge if they had complex health and social care needs. The PFC had access to information on care packages and bed availability across the local health and social care system. They also

had links to the local authorities and mental health trust. Staff referred patients to the PFC, where appropriate and we observed social workers attending the department to ensure patients had appropriate care packages in place prior to their discharge.

There was wheelchair access to all parts of the department and the reception desk had a hearing loop for those who had hearing impairments. The department did not comply with NHS England's Accessible Information Standard by identifying, recording, flagging, sharing and meeting the information and communication needs of patients with a disability or sensory loss.

The main waiting room did not always meet the needs of individuals. There was no reading material, Wi-Fi, television access or information about waiting time. There was a plasma screen displaying details of hospital facilities and health promotion information.

Translators could be accessed via the telephone translation system provided by the hospital. There was a spacious relative's room that could be used for family members of critically ill patients in the resuscitation room.

### Access and flow

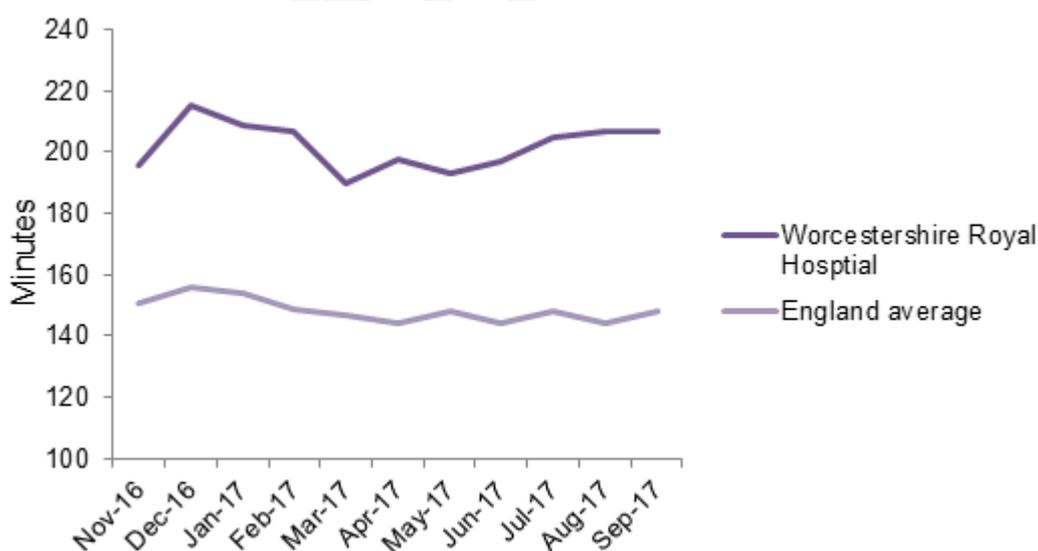
Many patients could not access the service when they needed it.

Previously, the trust was issued Section 29A Warning Notice due to the lack of effective plans to manage overcrowding in the ED. When we inspected in April 2017, the trust told us that they had developed a new 'full capacity protocol' to manage overcrowding; however, there was no evidence to confirm this was in place. The protocol in use was dated 2015 and actions to reduce crowding were ineffective.

Patients spent longer in this ED than at other trusts in England. The monthly total time spent in ED for all patients was consistently worse than the England average from November 2016 to September 2017; patients spent on average 202 minutes in the department.

During our inspection patients who needed to be admitted to a ward were spending up to 20 hours in the department. This meant that there was often no room for newly arriving patients.

### Median total time spent in ED per patient

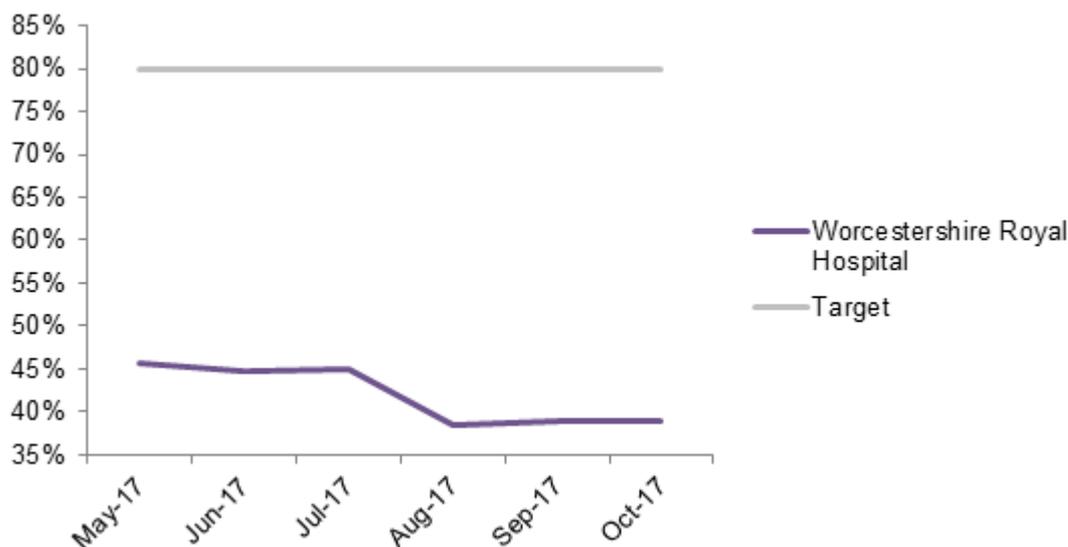


Some patients had to wait for specialist doctors to see them before they could be admitted. Despite internal professional standards stating that specialist doctors should respond within one hour of referral we observed patients waiting up to six hours before a specialist came to see them. Trust figures showed that the average wait was two hours. Delays during our inspection were longest for ear, nose and throat doctors and for general physicians. The longest waits occurred at 20180114 Worcesterstershire Royal Hospital; Urgent and Emergency Care Evidence Appendix FINAL DRAFT

night when there were fewer senior doctors in the hospital. This, in turn, delayed the time of the decision to admit. At the Worcestershire Royal Hospital the decision to admit is regarded as the responsibility of the specialist doctor, not the ED doctor. This applied even if the ED doctor was the more senior of the two.

Patients faced delays due to the timeliness of specialty doctors arriving to ED. From May to October 2017, the ED did not meet the 80% target for the percentage of patients receiving a specialty review within one hour of referral. 42% of patients received a specialty review within one hour of referral. This had not improved since February and March 2017, when 41% and 50% respectively, of patients received a specialty review within one hour of referral.

#### Percentage of patients receiving specialty review within one hour of referral

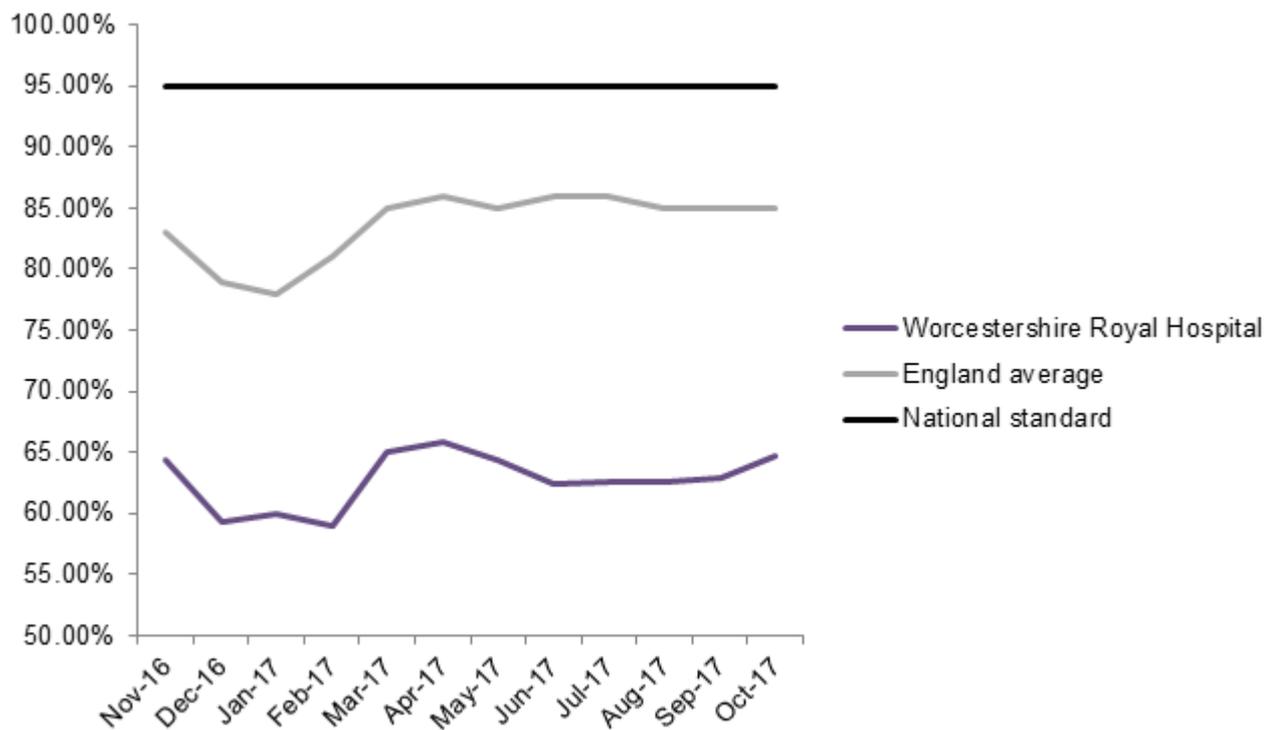


*(These figures only include where the Specialty arrival has been recorded.)*

Emergency departments in England are expected to ensure that 95% of their patients are admitted, transferred or discharged within four hours of arrival. This is known as the emergency access standard (EAS). The standard had not been met in any month at the Worcestershire Royal Hospital since November 2013.

The percentage of patients discharged from the department within four hours had not significantly improved during the last year. From November 2016 to October 2017, 63% of patients were admitted, transferred or discharged within four hours of arrival.

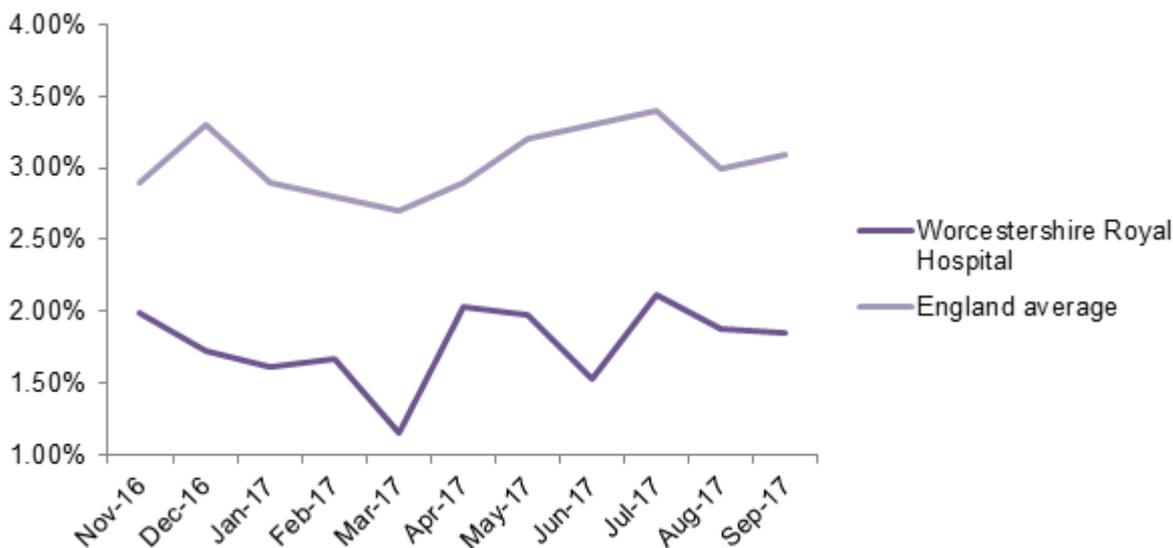
### Four-hour target performance



(Source: NHS England - A&E Waiting Times and WAHT Integrated Performance Report September 2017)

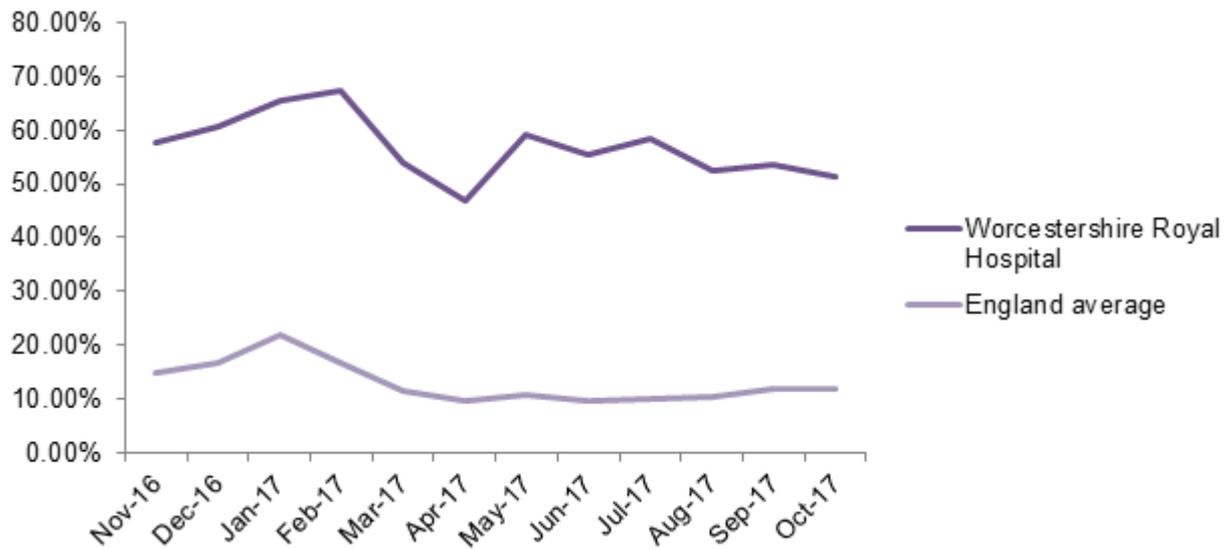
The ED performed better than the England average for the percentage of patients who left the department without being seen from November 2016 to October 2017. 1.8% of patients left this ED without being seen, compared to the England average of 3.2%.

### Percentage of patients who left the ED without being seen



Patient flow through the hospital had improved slightly since the inspection in November 2016 but performance remained inconsistent and was significantly worse than the England average. From November 2016 to October 2017, 57% of patients waited from four to 12 hours from the decision to admit until being admitted. In July 2017 59% had been admitted in this timeframe and in October 2017 it had gradually improved to 52%.

Percentage of patients waiting from four to 12 hours from the decision to admit until being admitted



From November 2016 to October 2017, an average of 3.6% of patients waited more than 12 hours to be admitted. However, no patients had waited more than 12 hours to be admitted since August 2017. This had improved significantly throughout the year, particularly compared to January 2017 when patients waiting more than 12 hours to be admitted peaked at 18.46%.

The table below shows the percentage of patients that waited more than 12 hours to be admitted.

Month	Worcestershire Royal
Nov-16	4.65%
Dec-16	10.87%
Jan-17	18.46%
Feb-17	7.35%
Mar-17	0.68%
Apr-17	0.40%
May-17	0.62%
Jun-17	0.11%
Jul-17	0.11%
Aug-17	0.00%
Sep-17	0.00%
Oct-17	0.00%

Patients who had been referred to the hospital by their GP were not taken directly to an acute assessment unit as recommended by the NHS Improvement document “Focus on improving patient flow (July 2017)”. Instead they were cared for by ED nurses while they waited for the specialist doctor who had accepted the referral from the GP. ED staff told us that, when delays were very long, some patients had to be treated by ED doctors.

The responsiveness of the mental health team (provided by another NHS trust) had been consistently good for the whole year. Since November 2016 between 95% and 100% of patients had been seen within one hour.

The hospital had an ambulatory emergency centre to help prevent unnecessary admission to a ward. The centre provided day case medical treatment. The trust had recognised that it was too small to respond to the demand for this type of treatment and was being rebuilt. It was due to open

at the beginning of December 2017 and it was anticipated that it would treat 20 patients a day. In the year ending October 2017 it had treated an average of four patients a day.

The department employed its own rapid response team who responded to patients with existing complex needs who had presented to the department with a minor injury or illness. The team consisted of two experienced nurses and two physiotherapists and provided a service seven days a week. They assessed the requirement for additional community assistance that would be required in order for the patient to be safely discharged home. Their strong links with the community meant that they were able to arrange additional support quickly enough to prevent the patient requiring admission to hospital.

There was a full capacity policy which described the actions to be taken if the ED was full and ambulances were no longer able to handover patients as soon as they arrived. We were told that this had been updated two weeks before our inspection and were shown actions cards held at the staff base and setting out actions to be taken by ED staff. We asked to see a copy of the protocol but were sent a draft copy and a statement stating "the Capacity Management Policy (Draft 2017 V.4) was under review and in draft format. This policy requires internal ratification as per governance processes". This meant it was possible that the ED was using a policy which had not been ratified and was not recognised by the rest of the hospital.

We requested information on the amount of times that the hospital had declared full capacity, but the trust did not provide us with this information.

The nurse in charge of the department attended a hospital capacity meeting three to four times a day. This was to update hospital managers on the capacity of the ED and to understand bed availability across the hospital. Capacity meetings were now held in a room next door to the major treatment area so that the nurse in charge did not have to spend significant period of time away from the ED.

When the ED was very full the hospital capacity meetings were led by the interim chief operating officer or another executive officer. It was attended by senior managers from different specialties in the hospital. During the meetings we observed clear objectives and timeframes being set for the admission of patients from the ED. There appeared to be a hospital-wide ownership of the delays and an eagerness to work together to reduce them. The interim chief operating officer started to identify empty beds for all patients who had been in the department for more than three hours and were likely to be admitted. This was an improvement compared to our April 2017 inspection when arrangements for admission only started once a patient had been seen by a specialist and a formal decision to admit had been made.

Shortly after the meeting we saw patients being moved from the ED corridor to wards in the hospital. However, between meetings very few empty beds seemed to be identified and the queue of patients in the corridor had built up once again.

### **Learning from complaints and concerns**

Complaints were not responded to in a timely way. The ED matron was aware that responses to complaints were not always completed within the trusts policy of 25 working days. This particularly applied to complex complaints involving multiple members of staff. However, the trust's governance department was now assisting with the investigation of complaints and the response rate had recently improved from 39 days to 32 days.

From August to October 2017, there were 75. The majority were about clinical treatment (53%).

Please see below tables that outline the complaints received by month and the themes of complaints:

## Complaints by month

Month	Oct -16	Nov -16	Dec -16	Jan -17	Feb -17	Mar -17	Apr -17	May -17	Jun -17	Jul -17	Aug -17	Sep -17	Total
Worcestershire Royal Hospital	10	10	6	6	9	6	2	6	3	2	9	6	75

## Complaints by subject area: Worcestershire Royal Hospital

Subject	Complaints
Clinical treatment	40
Admissions, disc and transfers	9
Patient Care including Nutrition and Hydration	8
Waiting times	5
Values and behaviour (staff)	4
Privacy, dignity and well-being	2
Trust administration	2
Appointments including delays or cancellations	1
Prescribing errors	1
End of life care	1
Access to treatment or drugs	1
Facilities Services	1
<b>Total</b>	<b>75</b>

(Source: Routine Provider Information Request (RPIR))

The complaint management process had recently changed so that senior ED staff had responsibility for complaints relating to their department. Previously, divisional managers were responsible for complaints. Staff could describe their approach to complaints. The new process was for senior nurses or consultants to gather information from relevant staff members and contact the complainant to apologise over the telephone, at the earliest stage possible. Staff informed complainants of their initial findings and offered further investigation, if the complainant wished. This would be followed up by a written response. Face-to-face meetings were offered after further investigation, if required. We looked at a recent complaint and found that this approach had been followed and that the complainant appreciated the early contact.

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Letters of response were discussed with an executive director of the trust board before being posted. No complaints had been referred to the Parliamentary and Health Service Ombudsman in the last year. Learning from complaints was shared with ED staff at twice daily handover sessions and we saw summaries recorded in the handover file. Staff were encouraged to reflect on practice and behaviour that may have led to the complaint.

## Is the service well-led?

### Leadership

The emergency department (ED) was previously managed as part of the trust's medicine division. Six weeks prior to this inspection, the medicine division was restructured into two smaller divisions: scheduled care and urgent care. The ED was now managed under the urgent care division, which included urgent and emergency care services only.

The urgent care division was led by a medical director, a director of nursing and a director of operations. The medical director for the division was acting up from their usual role of clinical lead of emergency medicine at Worcestershire Royal Hospital. The divisional director of nursing and director of operations were both substantive appointments and had worked at the trust for over a year.

The aim of the new divisional structure was to increase senior support for the ED. Staff spoke positively about the change and felt that leadership in the ED had improved. However, it meant temporary disruption to reporting structures and a vision and strategy for the ED that was in its early stages. They felt, previously, that it had been easy for the department “to get lost” in the very large medicine division and that, in future, there would be increased focus on the needs of patients and staff in the ED. Local leaders had welcomed the new, smaller division as they felt more empowered to drive improvement in the department.

The local leadership team for the ED consisted of a clinical lead who was a consultant in emergency medicine and a matron. The clinical lead and matron were highly visible in the department and often worked clinically to maintain their skills and support their staff. They clinically supported junior staff, leading the treatment of the sickest patients and dealing with the more complex situations that arose. They demonstrated the skills, knowledge, integrity and experience needed for their roles. Staff told us that they trusted the leadership team and knew that they would be listened to if they raised concerns. They told us that there was a “no blame” culture that made it easier to admit mistakes and to learn from them.

The new urgent care divisional structure included a general management position which had not been recruited to at the time of inspection. This meant local clinical leaders were responsible for all governance, quality and risk management in the ED. They were supported by divisional managers; however, it was evident from the quality of meeting minutes, information provided and what staff told us on inspection, that local clinical leaders did not always have capacity within their roles to focus on governance and performance to a sufficient level. This meant monitoring the quality and performance management of the department was not always a priority. Performance management figures that we saw were sometimes confusing. For example, one set of data stated that 253 ambulance crews had waited more than an hour to handover a patient to the ED staff, another said it was only 208 for the same time period. Lack of general management was highlighted as a concern during previous inspections.

The stability of trust-wide leadership had improved since the November 2016 inspection. There was a new substantive chief executive and chief nurse, along with other new executives. The chief executive and chief nurse were regular visitors to the ED and there were also monthly visits by other members of the executive team. Staff knew who the board members were and could recognise them from trust-wide communication. One member of staff told us “They don’t say a lot, but they do listen. That hasn’t happened for quite some time”.

## **Vision and Strategy**

There was no documented local strategy for the department. Following the division re-structuring a new strategy was being developed for the department. The leadership team described shared a vision and values, driven by quality and sustainability. They told us that the new strategy would be aimed at ensuring that 95% of patients spent less than four hours in the department thus allowing staff to deliver safe and effective care to all patients. In order to achieve this, the leadership team were already working with the local Clinical Commissioning Group on two projects. One was to establish an urgent treatment centre next to the ED for patients with primary care problems. The second was to allow direct discharges of appropriate patients to community hospitals and nursing homes. In addition, an agreement had recently been reached with the trust board regarding the expansion of the ambulatory emergency care unit to a seven day a week service. However, there was little evidence to show that this strategy was in place or that progress was monitored.

A divisional strategy was being developed for the urgent care division at the time of inspection; however, this had not been finalised or implemented.

The trust vision was 'Working together with our partners in health and social care we will provide safe, effective, personalised and integrated care for local people, delivered consistently across all services by skilled and compassionate staff.' The trust also had 'PRIDE' values. This stood for:

- Patients at the centre
- Respect for everyone
- Improve and Innovate
- Dependable
- Empower

## **Culture**

The culture in the ED had improved since previous inspections. In November 2016, there was trust-wide acceptance of long waits for patients and corridor care. At this inspection, although corridor care continued, the culture was now focused on teamwork and putting patients first.

Relationships amongst staff in the department were cooperative, supportive and appreciative. Nursing staff and medical staff shared responsibility and worked together for the benefit of patients.

ED staff told us that the culture within the hospital as a whole had not always been a positive one. This had been recognised by the new trust board and a cultural improvement project had commenced in August 2017. So far workshops had been held for almost 300 senior staff in the hospital including sisters, matrons, consultants and divisional managers. Staff who had taken part in a workshop were positive about the results. There was an increased emphasis on working together with other teams in order to improve the experience of patients in the hospital. A set of signature behaviours for staff had been agreed including "Do what we say we will do" and "We listen, we learn, we lead".

Many staff expressed a sense of despondency and resignation about the long delays for assessment and treatment and about having to care for patients in a corridor. Senior staff were frustrated that they had been unable to improve the situation. There was a sense of weariness associated with constant change which had resulted from a series of interim directors at board level in previous years. However, there was hope that some of the small improvements in recent months would gather in momentum and would lead to greater improvements.

Despite widespread frustration there was a positive culture in the department which was centred on the needs and experience of patients. One member of staff said "It's patients we are talking about here, not numbers." Staff told us that they felt respected and valued by their colleagues and the leadership team within the ED. One nurse said "I am proud to work with such a great team". Staff told us that the support they received from their colleagues in the department helped them to cope with the pressures which resulted when the department was very crowded.

The leadership team were concerned about the well-being of staff. "Decreased staff morale" was one of the consequences of the ED risks described on the divisional risk register. Leaders were aware that staff were often stressed and took opportunities to improve this where possible. For example, because it was often not possible for staff to leave the department for breaks, free breakfasts had been arranged each day and were delivered to the department.

Trust board members made regular visits to the department. The trust had recently implemented cultural improvement programme, '4Ward'. The 4Ward programme introduced a set of signature behaviours that the trust intended to become part of everyday practice. Senior ED staff felt this was having a positive effect. The signature behaviours were:

- Do what we say we will do
- No delay, every day
- We listen, we learn, we lead
- Work together, celebrate together

The trust had recently appointed a Freedom to Speak Up Guardian. However, staff in the ED did not know how to contact the Freedom to Speak Up Guardian or the purpose of this role.

## **Governance**

We asked for minutes of the last two ED clinical governance meetings but none were sent for Worcestershire Royal Hospital. Instead the trust sent minutes of the divisional management meetings, which had representatives from both trust EDs attending. However, attendance was variable from five people attending the meeting in August 2017, with neither the Worcestershire Royal Hospital clinical lead nor matron attending; to 12 people in the October 2017 meeting with the Worcestershire Royal Hospital clinical lead or matron attending.

Although the divisional management meetings included quality topics, such as HR, finance and some quality, the meeting did not demonstrate incidents and risks were discussed, like we would expect at a clinical governance meeting. We therefore could not be assured that the governance arrangements supported the delivery of good quality patient care. This was highlighted as an issue during the inspections in November 2016 and April 2017.

Senior nursing meetings minutes provided included some discussion around clinical governance including risk, plus complaints and staff training.

There were no joint governance arrangements between the ED and the out of hours GP service. There were no formal meetings to review the effectiveness of the streaming process.

The trust had recognised there were issues with the governance structure and arrangements in the ED. In the integrated performance report from September 2017, a decision was made for an executive director to support the urgent care division to improve their governance and performance management.

Senior staff we spoke with were clear about the challenges the department faced and they were committed to improving the patients' journey and experience. The clinical lead was reviewing the governance structure in order to make it more relevant to the new management structure. However, we were not assured that there was a systematic approach to improving the quality of services and safeguarding high standards of care.

## **Managing risks, issues and performance**

In the Section 29A Warning Notice issued in January 2017, risk management in the ED was an area where the trust was required to make significant improvement. The issues included lack of effective oversight of incidents and not all risks being identified and managed on the departmental or divisional risk registers. When we re-inspected in April 2017, little improvement had been made. We were not assured that risks, issues and performance were effectively managed in the ED and a further Section 29A Warning Notice was issued. This particularly related to the lack of effective plan to manage crowding and patients being cared for in the corridor.

During this inspection, there had been some areas of improvement, but issues remained. The department remained severely crowded and measures previously identified actions to prevent this had produced little significant improvement.

During periods of our inspection, the patient safety matrix showed the department was "overwhelmed" due to large numbers of highly dependent patients in the department. From August

to October 2017, trust data showed that safety levels in the department had been assessed as “critical” on 12 days; and the department had been assessed as “overwhelmed” on 77 days, or parts of days. The matrix did not contain guidance about what to do in these circumstances. Not all staff knew what actions they would take if the safety matrix confirmed that the department was overwhelmed. They had not been told that any action was expected and had been given the impression that the matrix was used for monitoring purposes only. We later asked a senior manager the same question. We were told that the safety matrix was displayed on computer screens accessible by senior managers throughout the hospital and that action would be taken but that ED staff may not be aware of it.

A ‘Surge and Escalation Management Protocol’ had been developed which included actions for ED senior clinicians to take in response to each category on the safety matrix. However, it was unclear if the protocol had been implemented as the document was not dated and staff we spoke with were not sure if it had been introduced. This meant that we were not assured appropriate action would be taken to manage the patient safety risk in the department when it was categorised as “overwhelmed”.

Risk management processes remained an area of concern. The ED did not have its own risk register. Senior staff were able to describe the main risks in the department and some departmental risks were reported on the urgent care divisional risk register. The risk register summary that was initially provided included a description of the risk, the effect and the impact but risks were not graded according to severity or likelihood and there were no mitigating actions or control measures recorded. It was therefore unclear how risks to patients were being managed and reviewed at departmental level. In response to us querying this, the trust provided a further document which contained more detail. This document showed risks relating to ED at the Worcestershire Royal Hospital were described within Datix risk management system. The fields within the Datix risk management system included risk rating according to consequence and likelihood which is recorded at first assessment, subsequent assessment is detailed within the body of the risk. All risks include a review date, controls, gaps in controls, assurances, gaps in assurances, and subsequent mitigating actions with action review dates. However, it was unclear how staff used both documents effectively to manage and mitigate risks.

The risks documented reflected some of the concerns described by staff in the department. For example, delays in assessing patients increase in children’s attendances without an increase in resources and low numbers of medical staff at night. Risks, such as long delays for admission to a ward or patients waiting in an un-monitored corridor were not recorded. However, these risks did feature on the corporate risk register and were graded as high risk. Staff were unsure about the process for departmental risks being entered on to the corporate risk register.

There had been some improvements since the November 2016 inspection, with regards to performance monitoring and review at local level. Recent changes to divisional structure meant performance management arrangements were not finalised at the time of inspection. However, there were processes to manage current and future performance. A weekly urgent care dashboard contained information about ambulance handover times, triage times, the emergency access standard and response times for specialty referrals. This was discussed at staff weekly meetings. The dashboard clearly showed whether performance was improving or declining and this was reviewed by the local leadership team. Where performance was declining, or was less than national targets, action plans were agreed and recorded. Information from the ED was included in the trust performance dashboard that was reviewed by the trust board each month.

There was a weekly urgent care performance review ‘performance factsheet’. The performance factsheet included a brief overview of the trust’s EDs but did not include any discussion around how performance could be improved.

There was a safety and quality improvement dashboard, known as the safety and quality information dashboard (SQuID), in use in the department. The SQuID displayed departmental information, such as the number of incidents, complaints, NEWS audit results, sepsis audit results,

falls and use of the safer staffing tool. Senior staff told us that this was discussed during staff meetings and staff handovers; however, as meetings were not minuted, we were unable to confirm this. This information was discussed at divisional level, but there was no evidence to show how the information was used to improve service delivery.

Senior staff told us that actions were agreed as necessary from the meetings. For example, nurses with additional training in the care of sick children were highlighted on the duty rota. This made it easier to ensure that there was one on duty at all times.

There had been an improvement in internal audit systems. In addition to the newly implemented clinical audit programme, there was also a systematic programme of internal audit to monitor nursing and care quality. This had been implemented in July 2017. Senior nurses conducted daily audits of patient records, including sepsis management. There were also weekly observational audits of the department to monitor compliance with the below questions:

Q1	Are all staff in correct uniform?
Q2	Is the medical notes trolley locked or supervised?
Q3	Is the nurse in charge (NIC) wearing the NIC badge?
Q4	Has a board round taken place?
Q5	Has the resuscitation equipment been checked in the previous 24 hours?
Q6	Are all staff bare below the elbows?
Q7	Has a nursing documentation pack been started?
Q8	Has the patient got a name band and is it the right colour?
Q9	Has the care and comfort round documentation been completed?
Q10	Have the NEWS been correctly calculated?
Q11	If the patient score is above 5, have they had a sepsis screen?
Q12	If required, have they been escalated to the NIC?
Q13	Has a skin map been completed?
Q14	If required, has action been taken to protect the patient?
Q15	Does the patient have a cannula?
Q16	Has the peripheral vascular disease (PVD) documentation been completed?

## Managing information

The department collected, analysed, managed and used information to support its activities, using secure electronic systems with security safeguards. The information was used to monitor the performance of the department.

The trust had recognised that the performance of the ED was closely linked to the performance of the rest of the hospital. In September 2017 ED performance meetings were superseded by capacity management meetings chaired by the interim chief operating officer. Performance was monitored and managed and using a “Weekly Dashboard”. This measured items such as compliance with the emergency access standard, time to assess patients and delays in response from specialist doctors and the numbers of patients who waited in corridors. It was not clear whether the last item included those patients who were waiting for treatment in the SIAN area. The dashboard was sent to the trust board on a weekly basis.

## Engagement

Patient’s views and experiences were gathered and we saw some evidence that they were acted upon. The department engaged with patients, staff, the public and local organisations to plan and manage appropriate services.

Staff from the department took part in patient’s forum meetings and the local Healthwatch group

had visited the department on several occasions. As a result, information for patients in the corridor had improved and bottles water was made available so that there was no delay in providing drinking water.

A liaison group with the local prison had recently been formed. Attendance at the ED by prisoners consumed significant resources. It was hoped that better communication and sharing of knowledge with healthcare staff at the prison would prevent some of the attendances.

The Friends and Family Test (FFT) response rates were consistently below 1% from November 2016 to October 2017. Improving FFT results for the ED was part of a trust-wide quality improvement plan; however, no actions to improve had been taken in the department. Staff did not actively encourage patients or visitors to fill in FFT feedback forms. This was a potential missed opportunity for learning and improving patient care

Monthly nursing staff meetings were held and were well attended. Topics, such as training, infection control and learning from incidents were discussed. Minutes of the meetings were sent to staff via e-mail and were posted on the staff noticeboard. Letters of thanks and praise for staff were also displayed on the staff noticeboard.

Prior to attending, the public could access live waiting times for the ED and neighbouring minor injuries units via the trust website. This meant people had a more informed choice when deciding which department to attend.

### **Learning, continuous improvement and innovation**

The trust had a quality improvement plan in place to address areas of concern identified in the Section 29A Warning Notices, requirement notices and previous inspections. In the ED, not all issues had been addressed.

Areas of concern highlighted in the Section 29A Warning Notice that had not improved:

- There was a significant number of patients who were cared for in the corridor during this inspection. Patients were still being cared for on trolleys in the corridor whilst waiting for admission to a ward or prior to a safe discharge.
- During periods of our inspection, the patient safety matrix showed the department was “overwhelmed” due to large numbers of highly dependent patients in the department. From August to October 2017, trust data showed that safety levels in the department had been assessed as “critical” on 12 days; and the department had been assessed as “overwhelmed” on 77 days, or parts of days. The patient safety matrix did not contain guidance about what to do in these circumstances.
- The ED performance remained inconsistent for the number of patients who were kept waiting for over 60 minutes before being handed over to ED staff and was performing worse than the England average.
- Although overall safeguarding children level 2 and 3 training compliance remained below 90%, there had been an improvement in compliance, particularly with medical staff.
- The level of consultant presence in the ED had not improved to meet RCEM recommendation of 16 hours per day, seven days per week.
- We were not assured Paediatric Early Warning Scores (PEWS) were consistently completed and escalated appropriately. From 28 July 2017 to 22 September 2017 calculation of PEWS varied from 75% to 100% and only 61% of high scores had been escalated to the appropriate staff member. However, we found seven sets of children’s records where a PEWS was appropriate, all had been completed correctly and, where necessary, escalated to a senior decision maker.

Areas of concern highlighted in the Section 29A Warning Notice where there had been some improvement:

- Hand hygiene and infection control precautions were consistently carried out.
- The mental health assessment room had been re-furbished since our April 2017 inspection so that it met the quality requirements of the Psychiatric Liaison Accreditation Network.
- There had been improvements in the administration of time critical medicines (TCM). Further training had been developed and incorporated into the induction, mandatory and junior doctor training. We also saw examples where the pharmacy team had highlighted TCM onto patients' medicine charts in order to avoid missed or delayed doses. We saw no patients wait for TCMs during our inspection. A seven day clinical pharmacy service had been commenced. This service was now fully embedded and part of the ED team. Members of the pharmacy team included four pharmacists and two pharmacist technicians. In particular the team focussed on patients who had been prescribed time critical medicines. For example, Parkinson's disease medicines, anticoagulants and insulin and ensured that there were no missed doses.
- Risk assessments for nutrition and hydration, pressure ulcers, frailty and venous thromboembolism (blood clots) were consistently carried out and were acted upon when necessary.

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