Care Quality Commission

Colchester Hospital University NHS Foundation Trust

Colchester General Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Inadequate
Urgent and emergency services	Inadequate
Medical care	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

Colchester General Hospital is part of the Colchester University Hospital NHS Foundation Trust. The hospital is an acute hospital providing accident and emergency (A&E), medical care, surgery, critical care, maternity, children and young people' services, end of life care and outpatient services, which are the eight core services always inspected by the Care Quality Commission (CQC) as part of its new approach to hospital inspection.

Colchester General hospital is a 608 bed district general hospital, in Colchester. The trust as a whole employs over 4,000 staff, the majority of whom are based at Colchester General. The hospital provided a range of elective and non-elective inpatient surgical and medical services as well as a 24-hour A&E, maternity and outpatient services.

We carried out this responsive inspection to respond to information of concern around performance and care received by patients in the accident and emergency department and the emergency assessment unit.

The inspection team consisted of six experienced CQC inspectors including one paramedic and four nurses, one inspection manager and the Head of Hospital Inspection for the area. The inspection took place on 12 November and we returned to follow up a whistleblowing concern on 27 November 2014. Both of these visits were unannounced.

Our key findings were as follows:

- Staff were exceptionally busy during our inspection and therefore did not always come across as caring to patients or treat patients with dignity and respect.
- We observed that the dignity of the deceased or dying was not always respected.
- Patients largely spoke positively about the care that they received although at some times communication needed to be improved.
- The emergency department was not always clean and staff in the emergency department and EAU did not adopt good hand hygiene techniques or hand washing practices.
- We observed that people's care was not always provided in their best interests in accordance with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- The risk of patient deterioration was not acted upon in a timely way because the early warning indicators of deterioration were not always acknowledged.
- The EAU did not operate their GP triage area because the 17 spaces had been converted into inpatient beds taking the unit to 62 beds in total.
- Staffing levels on EAU were not sufficient and had not been assessed based on patient acuity in line with NICE guidelines. The patients on the ward during our inspection required a higher level of care.
- Staffing levels in the emergency department were managed fluidly enough which left high risk areas such as resus short of staff on occasions.
- The surges in activity meant that people had long waits to access services.
- Patients were being stepped down from the emergency department resuscitation area into EAU without any clinical procedures in place to support patient care needs.
- Care in the emergency department did not always adhere to NICE guidelines, particularly around head injuries.
- Improvements were required in terms of the reporting and learning from incidents.
- Governance structures at a departmental level were not robust and were in significant need of improvement.
- Staff morale was very low across both areas and staff stress levels were high.

There were areas of poor practice found where the trust needs to make improvements.

Importantly, the hospital must:

- Ensure that a patient's mental capacity is assessed appropriately and that records are up dated and maintained in accordance with the Mental Capacity Act 2005.

Summary of findings

- Ensure that care provided in the best interest of the patient complies with the legal framework of the Mental Capacity Act Deprivation of Liberty Safeguards so that if a patient is restrained this is undertaken appropriately.
- Ensure that treatment in the emergency department particularly around head injuries and chest pain, is provided in accordance with NICE guidelines.
- Ensure that there is a standard operating procedure (SOP) in place for patients who are clinically assessed as safe to be 'stepped down' from the resuscitation department to the EAU.
- Ensure that the early warning score system (NEWS) is used effectively to respond to the risks of patient deterioration in a timely way.
- Ensure that there is a robust incident and accident reporting system in place to ensure that lessons learnt from investigations are shared with staff to improve patient safety and experience.
- Ensure that staff complete their mandatory training and have access to necessary training, especially safeguarding vulnerable adults and children, mental capacity and resuscitation, and development to ensure they maintain the appropriate skills for their role.
- Ensure that all patients' records are kept up to date and appropriately maintained to ensure that patients receive appropriate and timely treatment.
- Ensure that there are sufficient numbers of qualified, skilled and experienced staff at all times, particularly in the Emergency department and on the EAU.
- Review the patient flow from the A&E department to ensure that patients are assessed to meet their needs and there are no unnecessary delays.
- Review the complaints process to ensure that appropriate lessons can be learned and improvements made in service delivery.
- Ensure all staff adhere to the infection prevention and control of infection policy and procedures, particularly with regard to hand washing, cleaning procedures and curtain changes in the Emergency department and on the EAU.
- Ensure that do not attempt cardio-pulmonary resuscitation complies with best practice and national guidance, involves the patients or their representatives and that these discussions are recorded, those decisions are communicated with all staff to ensure that those decisions are respected.
- Ensure that the plans for escalation of high patient activity in the emergency department are reviewed to ensure that the service responds to surges of activity in a timely way.

We would normally take enforcement action in these instances, however, as the trust is already in special measures we have informed Monitor of these breaches, who will make sure they are appropriately addressed and that progress is monitored through the special measures action plan.

In addition, the hospital should:

- Review the involvement of staff within the emergency department and EAU to ensure that staff are fully aware and engaged with the trust vision, strategies and objectives and can contribute to the development of services.
- Ensure that the bed base within the EAU is maintained at 45 inpatient beds and 17 GP triage beds where reasonably practicable.
- Provide additional support to managers and staff within the emergency department and EAU at times of high service activity.
- Review the information following clinical audits and ensure that any actions and learning are shared with staff.
- Review the training available to staff on caring for people living with dementia or with a learning disability and provide training to ensure that staff have the appropriate skills for their role.
- Review the procedures within the emergency department of transferring or transporting deceased patients during periods of high activity to ensure the dignity of the deceased is respected.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating
Accident and emergency	Inadequate

Why have we given this rating?

Overall we found the A&E service at Colchester General Hospital was inadequate in the domains of safety, responsive and well led. We found that caring and effective domains required improvements.The A&E department was not safe because staffing levels for nursing and medical staff were not sufficient to provide safe care to patients. The service reported a high number of serious incidents with many having a significant or life changing impact on the patient. There was a lack of learning from incidents and no evidence was found or available which demonstrated learning from incidents had taken place to improve care.

We had to escalate the care of four patients to the attention of senior clinical staff because they were receiving inadequate treatment which placed them at risk of harm or deteriorating clinical conditions.

Infection control practices within the department were poor. We routinely observed poor hand washing techniques from staff between patients and patient records were poorly completed.

The service was not effective and required improvement. The department used evidence-based guidelines; however, these were not always followed or implemented at the appropriate early recognition time. Audit results did not always meet the required levels, for example 70% of septic patients had a full set of observations and a pain score within 15 minutes of arrival. The outcomes of people's care and treatment were not always effective. The latest nursing indicator results showed a poor level of outcomes for patients. Staff were not up to date with training in the Mental Capacity Act 2005. There was a lack of consistency in how people's mental capacity is assessed and not all decision-making was informed or in line with guidance and legislation.

The A&E department was not always caring. We had concerns during the inspection with how staff treated patients. We observed instances where patients were not treated with dignity or respect.

Services were not responsive. People experience unacceptable waits for some services. The department had surges of activity, which occurred on a regular and potentially anticipatory basis. The department struggled

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with space and staffing in coping with capacity issues with surges of activity. There were regular occurrences of ambulances stacking and waiting to handover within the department delaying the ambulance handover. Services were delivered without consideration of people's needs and complaints and concerns were handled inappropriately. Some patients who had been in ED overnight were not routinely offered drinks or snacks. One person who had been admitted to the department overnight had not been offered food and a drink until transferred to the ward the following day.
The leadership within the emergency department was inadequate. The service had been through many changes and turnover of staff was significant enough to cause the leadership to be insufficiently matured to ensure that patient needs and the demand on flow was maintained. The management changes that had occurred universally throughout the department had affected the morale of staff. The workforce were committed and loyal but showed stress related to work overload and staff did not feel respected, valued, supported or appreciated. There was a lack of clarity about authority to make decisions in relation to the department during busy periods. The top priority for the service at local management level was the delivery of the four hour target which had impacted, to a degree, the delivery for quality and safety.
Owing to the dependency of the patients in this area and the number of safeguarding concerns, the CQC took urgent action in alerting the trust to the issue. The trust took immediate action to address the issues raised and subsequently raised an internal major incident the following day. CQC monitored the implementation of the increased staffing, improved safeguarding and improved flow and capacity through a second unannounced visit and found the trust was taking action that was appropriate to meet the needs of patients in this area. However, we did not test how effective these changes were and the CQC will revisit in the near future to see the sustainability of improvements that need to be maintained. CQC and partners will continue to monitor this area closely.
Following our last inspection, new information of concern was received relating to the care patients received in the A&E department, including the risk that patients were being bedded in A&E due to capacity issues within the hospital and that there were

Summary of findings

insufficient staff on duty to care for patients in the department. The CQC determined it needed to return to the EAU and undertake a further inspection on 23 December 2014. We found further significant concerns relating to the care of patients within the A&E department and that people experienced significant delays due to ongoing surges in patient demand. The trust was not meeting the standard required to comply with regulations in A&E. We have judged that there has been a major impact on patients who use the service. This is being followed up and we will report on any action when it is complete.

Medical care

Inadequate

We returned to inspect the Emergency Admissions Unit in November and December 2014. We found areas of significant concern, which has affected the ratings in this service.

Summary from inspection 12, 27 November and 23 December 2014

At our inspection in May 2014 the medical care services were rated as requires improvement in all areas except for caring which was good. At this inspection we found that the safety, effective and responsive domains were now inadequate. Caring now required improvement and the unit still required improvement on leadership. The EAU was not safe because there was a lack of awareness and reporting of incidents and we were concerned staff could not identify safeguarding concerns. Staff on the EAU did not respond to high risk indicators on the NEWS around deteriorating conditions in the correct way. Patients were acutely unwell on the ward and were not being escalated or being cared for in a safe way.

The unit was not effective as we identified concerns about consent and assessment under the Mental Capacity Act which was routinely not undertaken. We also found that clinical procedures had been carried out on patients without consent or best interest's decisions being taken.

The EAU was not always caring, staff aimed to provide care but due to how busy the service was, the staff were unable to do so and we observed some poor interactions with patients. The EAU was not responsive because the ward had closed the GP triage area to make way for additional inpatient beds; this meant that patients had to go the accident and emergency department which increased their workload and

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delivery of their service. We found that patients were routinely moved out of hours. Staff had limited awareness in caring for patients with dementia or learning disabilities.
Following our last inspection new information of concern was received relating to the care patients received on the EAU including information that the bed base had been increased again without sufficient numbers of staff to ensure the safety of patients. The CQC determined it needed to return to the EAU and undertake a further inspection on 23 December 2014. We found further significant concerns relating to the care of patients on the EAU department and that people experienced significant delays due to ongoing surges in patient demand. The trust was not meeting the standard required to comply with regulations in EAU. We have judged that there has been a major impact on patients who use the service. This is being followed up and we will report on any action when it is complete.

Summary from inspection 6, 7, 8, 16 & 19 May 2014

Medical and nursing staff were observed to enter and leave wards without using hand sanitising gels. Staff were also observed removing gloves after tending to patients and move to other tasks without washing their hands. Overall we found the medicine areas to be clean and tidy. Equipment was generally clean and appropriate, but medicine was missing from one resuscitation trolley when it was checked.
Concerns were raised about staffing levels and the skill mix on a number of medical wards. A nursing staff analysis review had been carried out on a number of medical wards and two wards were identified as being at risk. The trust was not meeting its targets for mandatory training within the medical directorate. Nursing records were not consistently completed and areas for assessing risks to patients were not completed in a number of care records we viewed across all ward areas where we visited. Staff across the directorate reported that learning from incidents needed to be improved, as many said that there was only learning after Serious Incidents.
Although the trust has worked hard to identify areas where care needs to be improved, it continues to have an elevated Summary Hospital-level Mortality Indicator (SHMI). There was evidence of participation in national

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and local clinical audits, but staff reported a lack of feedback and learning where improvements were identified. There were good arrangements for multidisciplinary working within the directorate.
Patients and the relatives we spoke with told us that staff were caring, kind and compassionate. They said that medical staff were approachable. We observed medical and nursing staff treating patients sensitively and discreetly. The majority of patients we spoke with said that they had been involved in making decisions about their care and treatments and that they had been given advice and information. Some people told us that they had not been involved in making decisions about their care and treatment. Some said that they were unaware of their plan of treatment or the arrangements for their discharge from hospital.
The medical directorate services were generally responsive to the needs of patients. Improvements were needed in managing the flow of patients between EAU and other ward areas to reduce the number of transfers overnight.
The service requires improvement in leadership. Staff across the directorate reported a lack of engagement with senior management at executive-level. Nursing staff reported good support and engagement with the director of nursing, but said that there was a lack of visibility of other senior managers including the chief executive. Staff were aware of the vision and strategy for the trust, which had only been very recently introduced. Staff did not feel 'listened to' or involved in making decisions and there were issues around learning from incidents.

Inadequate

Colchester General Hospital

Detailed findings

Services we looked at
Urgent and emergency services; Medical care (including older people's care)

Contents

Detailed findings

Background to Colchester General Hospital

Colchester General Hospital is a medium sized teaching hospital in Colchester with approximately 600 beds and is the main acute site for Colchester Hospital University NHS Foundation Trust. The hospital provides a range of elective and non-elective inpatient surgical and medical services as well as a 24-hour A&E, maternity and outpatient services to a surrounding population of around 370,000.

In 2013, the trust was identified nationally as having high mortality rates and it was one of 14 hospital trusts to be investigated by Sir Bruce Keogh (the Medical Director for NHS England) as part of the Keogh Mortality Review in May that year. Following concerns regarding the authenticity of cancer waiting times the trust was placed in Special Measures by Monitor in November 2013

At that time there was a significant turnover of the executive team. In addition the Chief Executive in post at the time of our inspection was replaced shortly afterwards.

Our inspection team

Head of Hospital Inspections: Fiona Allinson, CQC

Inspection Manager: Leanne Wilson, CQC

The team included six CQC experienced inspectors

How we carried out this inspection

Pre-inspection

The on-site element of the inspection was preceded by a review of intelligence by the inspection team. This phase involves collating data held by the CQC as part of our ongoing monitoring of the trust.

Public involvement

While on site, we spoke to service users in clinical areas. During and after the inspection members of the public and patients were encouraged to call or email CQC to share their experience of using the service.

Internal stakeholders

During the inspection, we talked to staff from all staff groups, allowing them to share their views and experiences with us.

Inspection

The inspection involved an on-site review of:

- Urgent and Emergency Services
- Medical care – specifically the Emergency Assessment Unit

The on-site element of the inspection involved two subteams of inspectors, each looked at one the services listed above. The teams undertook a number of methods of inspections from staff interviews to direct observations of care. Members of the trust board and senior management team were also interviewed.

Post inspection

The trust was asked to submit a significant number of documents as evidence of their performance around quality and service delivery.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Requires improvement	Requires improvement	Inadequate	Inadequate	Inadequate
Medical care	Inadequate	Inadequate	Requires improvement	Inadequate	Requires improvement	Inadequate
Overall	Inadequate	Requires improvement	Requires improvement	Inadequate	Requires improvement	Inadequate

Urgent and emergency services

Safe	Inadequate
Effective	Requires improvement
Caring	Requires improvement
Responsive	Inadequate
Well-led	Inadequate
Overall	Inadequate

Information about the service

Our inspection included one day in the emergency department across all areas as part of an unannounced responsive inspection due to concerns raised and information received to the Care Quality Commission (CQC).

The emergency department (ED) at Colchester General Hospital provides a 24-hour, seven day a week service to the local area. The department sees around 76,000 patients a year.

Patients present to the department either by walking in via the reception or arriving by ambulance. The department had facilities for assessment, treatment of minor and major injuries, a resuscitation area and a children's emergency department service.

The department has undergone extensive construction work to increase space, including adding three additional beds within the resuscitation area. Increasing the amount of cubicles within the major's assessment and treatment area and an identified ambulatory care cubicle. Ongoing construction work of a clinical decisions unit (CDU) was taking place during our inspection with a planned date for completion in January 2015.

Patients attending the accident and emergency department should expect to be assessed and admitted, transferred or discharged within a four-hour period. If an immediate decision could not be reached, a patient may be transferred to the emergency assessment unit (EAU), for up to 48 hours. Once patients were admitted to the EAU, they were cared for by the medical team.

Summary of findings

Overall we found the A&E service at Colchester General Hospital was inadequate in the domains of safety, responsive and well led. We found that caring and effective domains. The A&E department was not safe because staffing levels for nursing and medical staff were not sufficient to provide safe care to patients. The service reported a high number of serious incidents with many having a significant or life changing impact on the patient. There was a lack of learning from incidents and no evidence was found or available which demonstrated learning from incidents had taken place to improve care.

We had to escalate the care of four patients to the attention of senior clinical staff because they were receiving inadequate treatment which placed them at risk of harm or deteriorating clinical conditions. Infection control practices within the department were poor. We routinely observed adopt poor hand washing techniques from staff between patients and patient records were poorly completed.

The service was not effective and required improvement. The department used evidence-based guidelines however, these were not always followed or implemented at the appropriate early recognition time. Audit results did not always meet the required levels, for example 70% of septic patients had a full set of observations and a pain score within 15 minutes of arrival. The outcomes of people's care and treatment was not always effective. The latest nursing indicator

Urgent and emergency services

results showed a poor level of outcomes for patients. Staff were not up to date with training in the Mental Capacity Act 2005. There was a lack of consistency in how people's mental capacity is assessed and not all decision-making was informed or in line with guidance and legislation.

The A&E department was not always caring. We had concerns during the inspection with how staff treated patients. We observed instances where patients were not treated with dignity or respect.

Services were not responsive. People experience unacceptable waits for some services. The department had surges of activity which occurred on a regular and potentially anticipatory basis. The department struggled with space and staffing in coping with capacity issues with surges of activity. There were regular occurrences of ambulances stacking and waiting to handover within the department delaying the ambulance handover. Services were delivered without consideration of people's needs and complaints and concerns were handled inappropriately. Some patients who had been in ED overnight were not routinely offered drinks or snacks. One person who had been admitted to the department overnight had not been offered food and a drink until transferred to the ward the following day.

The leadership within the emergency department was inadequate. The service had been through many changes and turnover of staff was significant enough to cause the leadership to be insufficiently matured to ensure that patient needs and the demand on flow was maintained. The management changes that had occurred universally throughout the department had affected the morale of staff. The workforce were committed and loyal but showed stress related to work overload and staff did not feel respected, valued, supported or appreciated. There was a lack of clarity about authority to make decisions in relation to the department during busy periods. The top priority for the service at local management level was the delivery of the four hour target which had impacted, to a degree, the delivery for quality and safety.

Due to the dependency of the patients in this area, the number of safeguarding concerns the CQC took urgent action in alerting the trust to the issue. The trust took immediate action to address the issues raised and subsequently raised an internal major incident the following day. CQC monitored the implementation of the increased staffing, improved safeguarding and improved flow and capacity through a second unannounced visit and found the trust was taking that was appropriate to meet the needs of patients in this area. However we did not test how effective these changes were and the CQC will revisit in the near future to see the sustainability of improvements which need to be maintained. CQC and partners will continue to monitor this area closely.

Following our last inspection new information of concern was received relating to the care patients received in the A&E department including the risk that patients being bedded in A&E due to capacity issues within the hospital and that there were insufficient staff on duty to care for patients in the department. The CQC determined it needed to return to the EAU and undertake a further inspection on 23 December 2014. We found further significant concerns relating to the care of patients within the A&E department and that people experienced significant delays due to ongoing surges in patient demand. The trust was not meeting the standard required to comply with regulations in A&E. We have judged that there has been a major impact on patients who use the service. This is being followed up and we will report on any action when it is complete.

Urgent and emergency services

Are urgent and emergency services safe?

Inadequate

The A&E department was not safe. We found that whilst staff tried to provide good care the staffing levels for nursing and medical staff was not sufficient to provide safe care to patients within the treatment areas and in particular the resuscitation area. We identified concerns about the level and experience of staffing throughout the department. We spoke with members of staff about the availability of experienced emergency department nurses and we were told that there are not enough nurses with specific skills in areas such as triage which presented a risk to patients. Gaps in staffing were filled using bank and agency nurses who may have variable levels of experience and competency. The department only employed three full time consultants and gaps were filled using locum medical staff, although these provided longer term cover.

The service reported a high number of serious incidents since our last inspection in May 2014, with many of these incidents having a significant impact on the patient involved. The incidents were not accurately graded by staff and on occasions downgraded by senior staff. Therefore some incidents were not investigated at appropriate levels. There was a lack of learning from incidents and no evidence was found or available which demonstrated learning from incidents had taken place to improve care.The trust has made us aware of the revised governance arrangements it has put in place for the management of serious incidents.

Despite standard operating procedures for triage, assessment, treatment and observation in place we had to urgently escalate four patients to the attention of staff because they were receiving inadequate treatment which placed them at risk of harm or deteriorating clinical conditions. Mandatory training levels were lower than expected and this resulted in staff being unaware of current procedures.

Infection control practices within the department were poor. We routinely observed staff adopt poor hand washing techniques between patients, on several occasions staff did not wash their hands between patients and staff on several occasions wore the same gloves and aprons between patients. Patient records were poorly completed with sections of required information on clinical assessments, triage, observations and mental capacity not routinely completed.

The department had a waiting area for patients that walked into the department requiring treatment. We found that the waiting area was cold and had limited seating available. There was no information displayed advising people what to do should their condition worsen. The waiting area for the GP referrals and ambulatory care was located in the majors department near patients receiving treatment which was not appropriate and did not have due regard for the impact on people's safety.

Incidents

- The trust reported 15 serious incidents (SI) relating specifically to the emergency department to the National Reporting and Learning System (NRLS) and The Strategic Executive Information System (STEIS) since our last inspection in May 2014 to 31 October 2014. They included four incidents with the level of harm reported resulting in moderate harm, three incidents reported as severe harm and one incident resulting in death.
- The department had recently had a never event where a patient was administered the wrong gas through a breathing mask. A never event is an incident that should never happen. When asked staff in the department were not all aware of the potential never event or what learning had been implemented following the incident.
- We examined the serious incidents that had been reported by the service and found that the impact of the incident was not appropriately graded. The options for grading are No harm, low harm, moderate harm, severe harm or death. For example one case of delayed care of a HP triage patient where the patient died was graded as 'low harm'. Another case where there was a delayed diagnosis of a brain tumour was graded as 'no harm'. Therefore we were not assured that staff within the service and the trust recognised the severity of incidents when they were reported. This meant that investigation of such events could be affected if not triaged and investigated appropriately.
- We asked staff if they reported incidents and had knowledge of the reporting system. Staff told us that they reported incidents when they had time. They

confirmed that incidents were reported through the hospital internal reporting system but not all staff that reported incidents received feedback on outcome and closure on incidents they reported.

- We spoke with senior nursing staff about evidence of learning from incidents. No evidence was available or provided which demonstrated learning from incidents or showed an example of a change of practice resulting from incidents.
- During our inspection we pathway tracked a serious incident that had been investigated earlier in the year with regards to mental capacity assessment awareness. The trust decided to implement that all patients required a mental capacity awareness check on admission. We examined eight patient records and found that only one set of notes had this section completed. Therefore we were not assured that learning from incidents was taking place.
- We reviewed the mortality and morbidity meeting minutes for July, August and October 2014. Only one meeting had attendance from executive team members. No meetings had attendance from junior grade doctors and only one was attended by a middle grade doctor.
- Individual cases were discussed at each meeting and conclusions were drawn at the end of each meeting. However no actions were taken from each meeting or followed up at the following meeting to improve care and patient outcomes.

Cleanliness, infection control and hygiene

- We viewed the mandatory training records which showed that 66% of staff had received infection control training including hand hygiene. However during our inspection we observed poor practices within regards to infection control techniques. We witnessed staff not wearing gloves or aprons where required. Not all staff washed their hands between patients or used hand sanitizer.
- We observed a member of staff prepare sutures for a patient. The staff member put on sterile gloves and then had to leave the patient. They left the patient and entered the sluice room wearing gloves and an apron and then return to the same patient wearing the same gloves and apron to begin treatment.
- We were significantly concerned about the poor practice observed and immediately informed the Executive Team about this during our inspection. We were told that staff was spoken to and advice provided on best practice with regards to inspection prevention and control.
- We noted during our inspection that there was hand cleaning stations within treatment areas. Hand sanitizer was found at each door entrance and was full. We observed ambulance staff remove dirty linen and clean ambulance stretchers within the same area that patients were handed over. There was a specific designated area for this but it was not proactively managed or encouraged.
- Clinical sharps bins were available but not all sections were completed by the person who assembled the clinical waste bin. For example, the date when the bin was assembled and the name of the person who assembled the bin.
- We looked at all areas of the department during our inspection. We noted that for the duration of our inspection the department was busy and found at various times that the cubicles had not been cleaned in between patients. Within the resuscitation area we found that trollies and resuscitation bays were not cleaned between patients and found plaster, bandage tape and other items on the floor. Patients within these areas could have invasive procedures carried out which a high a risk of infection.
- The resuscitation area became busy during our inspection and we observed a member of staff remove soiled linen from a trolley and replace it with clean linen without any cleaning of the trolley. We highlighted this to the member of staff and were told that it is too busy to clean the trolley.
- We noticed during our inspection a new extended area within the major's treatment area which had no protective covering over the concrete. This meant that the floor could not be cleaned if the area was in use. We were told in the morning of our inspection that this area was not being used for patient care due to the flooring issue. However, later within the day of our inspection we found patients being cared for in this area which created an infection control risk. We escalated our concerns regarding this area to the Executive Team who immediately closed the area.
- During our inspection on 23 December we observed the movement of staff during patient care. We observed two doctors and three nurses move between different patients without performing any hand hygiene. We also

observed one doctor cannulate a patient within the resuscitation area placing the sharps onto the patients bedding and not direct into a sharps container. Therefore we were not assured that practices in relation to infection prevention and control had improved.

Environment and equipment

- The emergency department had a designated children's department which had a secure access and flow through the department. The children's emergency department had a dedicated waiting area that was appropriately decorated and equipped for children waiting to be seen.
- We found the ambulance entrance had broken doors and propped open. This meant that department was not secure and we observed members of public walk through past the resuscitation area and an area where supplies were stored. We spoke with a senior nurse who informed us that it happened over night. However, upon checking records and speaking with other managers and ambulance staff the doors had been broken for a longer period. We identified this to the trust and were informed that action would be taken immediately to rectify to fault.
- Each resuscitation bay had a clear display unit with emergency equipment labelled to negate any confusion with staff that was not familiar with the equipment.
- We looked at emergency resuscitation trollies within the department and found the trollies within the children's emergency department and resuscitation areas had been checked daily and this was consistent. We checked the resuscitation trollies in the major's treatment areas and the ambulatory care area and found several gaps in the checking history over the previous two months.
- Ambulance crews waiting to handover a patient had no ability to handover confidential information. The ambulance handover area was inadequate in these aspects whereby members of the public could stand in this area and hear confidential information. We observed this twice during our inspection and this was not challenged by the triage nurse taking the handover.
- We looked at various pieces of equipment across all areas within the A&E department. We found inconsistency with regards to scheduled servicing with some pieces of equipment being a year out of date from the recommended service. This was identified through the trusts internal service stickers on each piece of equipment.
- The emergency department had a designated ambulatory care bay in a separate area away from the major's treatment area. We noticed during our inspection that people were waiting on chairs within the corner of the major's treatment area and that the amount of people waiting increased during our inspection. We asked what this area was used for and were told this was an area for overflow ambulatory care patients and GP referrals. This was not an appropriate waiting area.
- The waiting area is a temporary building added on to the new extension. The waiting room is small with limited seating and was cold on the day of our inspection. There was no information displayed advising people what to do should their condition worsen, for example if they developed chest pain. There was no ability for the triage nurse to have an overview of the waiting area and the reception staff had no global view of the whole of the waiting room should someone become suddenly unwell or collapse which meant that the waiting areas was not clinically safe.
- During our inspection on 23 December we found that the safety checks on emergency equipment specifically the resuscitation trolley within the majors area had not been checked for eight days in the month of December. Patients could have been placed at risk of harm if appropriate equipment was not available in the event of a patient requiring resuscitation.

Medicines

- During our inspection we checked the records and stock of medication including controlled drugs and found correct and concise records with appropriate daily checks carried out by qualified staff permitted to perform this task.
- We looked at patient prescription charts which were completed and signed by the prescriber and by the nurse administering the medication.
- We found during our inspection that drug cupboards had been left open and insecure and medicines. For example, eye drops had been left on tables. We brought this to the attention of a senior nurse who took appropriate action immediately.
- Intravenous fluids were not stored securely. These were stored in an open public area within the major's

treatment area. With the rear doors to the department not being secure and a having a public waiting area within the majors area meant that any person could access the IV fluids.

Records

- It had been identified at the inspection in May 2014 that records were not stored securely within the emergency department. We followed up on this concern on our unannounced inspection and found that records were now stored securely and safe.
- We looked at eight sets of accident and emergency clinical notes during our inspection. All of the notes we looked at did not have completed observations taken with regular re-assessments recorded. One set of notes only had the ambulance service observations and no further observations had been taken by the emergency department upon admission of the patient in the emergency department.
- We observed that patient observations were included throughout the patients records and were difficult to find because pages were not easily defined between clinical observations and nursing/medical notes.
- We saw within the twelve accident and emergency notes, we reviewed, that not all risk assessments were undertaken in the department when patients were in the department for long periods of time. It is recommended by the Royal College of Nursing that if patients are in an area for longer than six hours, a risk assessment for pressure ulcers should be completed. The trust uses NICE guidance and initiate interventions for the falls prevention integrated care pathway within 12 hours from either admission or following identification of risk.
- We saw within records that not every patient, despite their age had a Waterlow body map completed. The Waterlow score or Waterlow scale gives an estimated risk for the development of a pressure sore in a given patient.

Safeguarding

- We spoke with staff including nurses, doctors, reception and housekeeping staff who understood their responsibilities and they were aware of the trusts safeguarding policies and procedures We did this because at previous inspections there had been concerns around safeguarding of children. Staff could describe the procedure to be followed if there was a concern about a child. If concerns were identified the department would discuss it with the safeguarding lead.
- We looked at training records and saw that nursing staff had undergone mandatory safeguarding training to an appropriate level. Compliance of training for safeguarding adults level 1 was 97% and safeguarding children level 1 was 94%.
- Despite the majority of staff receiving training not all staff we spoke to had knowledge of what constituted a safeguarding referral for an adult. We also saw that not all adult safeguarding referrals were followed up. We asked what service the department offers or actions it takes to support people that attend the ED on a regular basis. There is no support network in place to manage or support these people. Therefore we were not assured that patients who required safeguarding support would receive the appropriate treatment.

Mandatory training

- We were provided with records of mandatory and supplementary training for all nursing and medical staff with varied compliance across the multi-disciplinary teams.
- Records demonstrated that for nursing and medical staff in the department 84% had received Basic life support - adult training, 74% had received basic life support – paediatric training, 34% had received information governance, 56% had received manual handling (patient) and 61% had received risk management training.
- Mandatory training was provided in different formats including face to face classroom training and E-learning (E-learning is electronic learning via a computer system) although staff told us that there was limited time allowed to complete extra training.

Management of deteriorating patients

- We observed that the department operates a triage system of patients presenting to the department either by themselves or via ambulance and are seen in priority dependent on their condition.
- Patients arriving as a priority (blue light) call are transferred immediately through to the resuscitation area. Such calls are phoned through in advance (pre-alert) so that an appropriate team are alerted and prepared for their arrival.

- We looked at a pre-alert form with regards to a pre-alert that occurred during our inspection and found that the forms had been completed fully with any clinical observations recorded, estimated time of arrival of the ambulance to the accident and emergency department and who took the details over the telephone from the ambulance service.
- We had to escalate concerns regarding the care of four patients to the attention of the nurse in charge during our inspection. These patients were not receiving the appropriate care or early intervention as recommended by national guidelines such as the National Institute of Clinical Excellence (NICE) and the College of Emergency Medicine (CEM).
- Two patients had head injuries and had inadequate levels of neurological observations recorded. The third patient with acute chest pain had not had their echocardiogram (ECG) escalated to a doctor nor were they seen by a doctor for more than 45 minutes after being taken despite noticeable changes on their test which indicated a heart problem. The fourth patient was going to be discharged from the department following trauma without having diagnostic tests undertaken. When escalated staff recognised the seriousness of the condition and immediately undertook tests
- The accident and emergency department operates a national Early Warning Score (NEWS) alert system to monitor the condition of patients and alert them to any changes. The NEWS systems is based on a simple scoring system in which a score is allocated to physiological measurements already undertaken when patients present to, or are being monitored in hospital. We reviewed eight sets of notes and found within five patient notes that the NEWS score had not been recorded and in a further two sets of notes that the NEWS score had been calculated wrong with a lower score which meant that these patients were not receiving the appropriate recommended level of observation and were placed at risk of harm.
- Of the 15 serious incidents reported since our last inspection four related to the deterioration of patients without adequate monitoring. One example being a patient admitted to department in June 2014 but due to clinical factors they deteriorated within department. It was later established that the patent had a NEWS score of 13 but was still transferred to the EAU in a critical state without the correct interventions in place no observations completed since 09:45.

Nursing staffing

- Information provided by the trust indicated that the establishment for the accident and emergency department was not operating at the required whole time equivalents (WTE) with a number of qualified nurse posts vacant. Senior staff acknowledged that they were not meeting the RCN 'BEST' policy to their staffing needs and they were actively recruiting.
- We looked at nursing rota and saw that the department was often short staffed on a daily basis and was reliant on the use of agency nurses in all areas within the department.
- We saw that a recent skill mix review had taken place and the skill mix request was authorised this is yet to be put into place within the department and they are currently out to recruitment.
- The department did have a sufficient whole time equivalent of nurses with specific paediatric qualifications working within the paediatric ED to provide a 24 hour a day seven days a week service. When they were on shift they would be assigned to the paediatric service within emergency department and would be supported with other nurses. The department was also supported by paediatric nurses from the paediatric ward.
- The accident and emergency department is very reliant on bank and agency staff which can pose a risk to safety due to lack of familiarity with the department and varying levels of competency. However, these staff should have received local induction prior to starting their shift but the competency was varied between what nursing agencies were used.
- During our inspection we observed within the resuscitation area and found that this area was under staffed in accordance with BEST Guidance 2013 and cared for patients that required a ratio of 1:2 (1 nurse for every 2 patients) and on occasions a ratio of 1:1. We noted that there was one qualified nurse at the time of our observation looking after four patients. The department became very busy and it was not until it became a serious concern that the management within the department reacted.

Urgent and emergency services

Medical staffing

- The department currently operates at the England average of 23% whole time equivalent (WTE) of consultants employed within a rota. However only three consultants were permanently employed by the hospital the remainder were on locum contracts.
- Consultant grade doctors are present in the department for fifteen hours each day. Emergency departments should have consultant cover for sixteen hours each day and the current consultant rota did not support this. There were middle grade doctors and junior doctors overnight with an on-call consultant system. The department had a clinical lead but they were from the medical speciality not from within the emergency team.
- There was a shortage of middle grade doctors within the department which inhibited the ability to make definitive decisions around patient care, admissions and discharges.
- The department regularly employed locum middle grade doctors. When we reviewed the rota we noted that the same doctors were consistently being used. Doctors had received the trust induction programme and were familiar with the department and protocols.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

The service was not effective and required improvement. The department used evidence-based guidelines for example; there were a number of care pathways in the department for patients with specific conditions to follow, such as the stroke and sepsis pathway. However, these were not always followed or implemented at the appropriate early recognition time.

The participation within local audits was varied within the emergency department teams and some teams had returned a zero return with no audits carried out. Audit results did not always meet the required levels, for example 70% of septic patients had a full set of observations and a pain score within 15 minutes of arrival. The required target is 90%.

The outcomes of people's care and treatment demonstrated that the service offered was not always effective. The latest nursing indicator results showed a poor level of outcomes for patients attending with fractured neck of femur injuries receiving analgesia, as well as other nursing indicators around cannulas and monitoring for deterioration in a timely way.

We spoke with doctors and nurses about the implementation of National Institute for Health and Care Excellence (NICE) guidelines. They told us that, as NICE guidance was issued, they made sure that any relevant to the ED were implemented and that staff were aware of the requirements.

Nurse medical appraisal rates were lower than expected. We found that no clinical supervision was undertaken in the service. Staff attended regular team days in which they received updates on issues and training however staff found it difficult to access internet based training and had to complete this in their own time due to pressures in the department.

We found that staff were not up to date with training in the Mental Capacity Act 2005. There was a lack of consistency in how people's mental capacity was assessed and not all decision-making was informed or in line with guidance and legislation.The trust had introduced a policy that required all patients to have a capacity assessment undertaken however this policy was not being followed at the time of our inspection.

Use of National Guidelines

- The department took part in the national College of Emergency Medicine (CEM) audits in 2013. The results of the audits were same as when we inspected in May 2014 and no new audit data was available for this inspection which was expected.
- Since the audits were undertaken on areas including the severe sepsis and septic shock audit (last completed in 2011-2012), will show a decline in performance based on the evidence gathered during this inspection because sepsis bundles were poorly completed. We spoke with doctors and nurses about the implementation of National Institute for Health and Care Excellence (NICE) guidelines. They told us that, as NICE guidance was issued, they made sure that any relevant to the ED were implemented and that staff were aware of the requirements. Audit results supported what we were told.

- Local policies were available within the department, staff reported to us that they were aware of the procedures and used them when needed. There was a range of emergency department protocols available which were specific to the department.
- Trust guidelines and policies were available, for example, sepsis and needle stick injury procedure. However in four of the patient records we examined had not followed the guidelines. For example, a patient with a head injury did not have any neuro observations taken within the required timeframe.

Care plans and pathway

- There was a clear protocol for staff to follow with regards to the management of stroke, fractured neck of femur and sepsis. The department had introduced the 'Sepsis six' interventions to treat patients. Sepsis Six was the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis.
- We looked at recent audit data which demonstrated that the emergency department was not performing at the required target levels. For example, 70% of septic patients had a full set of observations and a pain score within 15 minutes of arrival. The required target is 90%.
- Nurses at the ED at Colchester General Hospital did not obtain blood cultures from patients who were queried as being septic and were reliant on doctors obtaining these blood samples. This meant that the process was reliant on a doctor being available and the care pathway delayed with regards to the treatment of antibiotics. This could place the patients at risk of harm or deterioration.
- At our inspection on 23December we looked at five patient records. In one record the sepsis pathway had been commenced and the 'yes' box ticked to consider the patient for the sepsis bundle as they had a high NEWS score and temperature. However, it was not further completed and investigations including urine specimen that would be required were not completed. We brought this to the attention of senior staff immediately. We could find no rationale in the notes as to why the sepsis pathway was not continued.
- We found a further two patients who had been commenced on intravenous antibiotics for possible infection but the sepsis pathway did not appear to have been considered and no rationale as to why it had not been used though the guidance on the tool states it should be considered for patients with a possible infection.

Nutrition and hydration

- The department did not take regular food and drink rounds 24 hours a day seven days a week and it was observed during our inspection that should patients require something to eat or drink then they would have to find a nurse to ask and request if they could have something.
- We spoke to two patients who told us that they had not had any water to drink for a long time. Another patient that was being treated with oxygen over a long time period had not had any mouth care and had dry membranes in the mouth. We mentioned this to a nurse who took immediate action.
- Due to the length of time some patients were required to stay in the department patients risks becoming dehydrated without access to regular fluids.
- The trust performs worse than other NHS trusts for this element of the CQC A&E patients' survey in 2014 scoring 5.6 out of a possible 10.

Outcomes for the department

- We were informed that the department took part in local nursing quality indicators. The majority of results showed a poor level of outcomes for patients. For example, only 14% of patients with a fractured neck of femur received analgesia within 20 minutes of arrival to the department, 60% of patients had their cannula dated, documented and a bionector connected, 30% of patients had a NEWS score recorded at least 15 minutes before discharge or transfer. Therefore patients were not receiving treatment in a timely or effective way.
- We asked the department what audits were undertaken to assess compliance with procedures and standards associated with these target levels. We were informed that no local audit learning had been undertaken. Therefor there was no evidence that the results had been used to improve the effectiveness of the department.
- Nursing teams were divided into four teams for the purpose of quality indicators. The audit return from the teams was varied with one team not submitting any

data and no audits had been carried out by that team. Therefore there were no audit results for the management of head injury for the ED to assess the care and treatment provided to people.

Competent staff

- Nursing staff appraisal rates for the department were at 67%. Staff we spoke with who had an appraisal spoke positively about the process and that it was of benefit.
- Of the medical staff 45% of had an appraisal undertaken. Medical revalidation in the department was also being undertaken.
- We found that no clinical supervision was undertaken in the service. Staff we spoke with felt that clinical supervision would be beneficial.
- The training records we viewed demonstrated not all medical and nursing staff were revalidated in basic, intermediate and advanced life support.
- Staff we spoke with told us that they found it difficult to access training to make sure they were up to date with their current practice and had to complete this in their own time due to pressures within the department.
- Non clinical staff told us that they received the mandatory training for their role, but had not received any training about how to work with patients with dementia, who they often had to deal with in the ED.

Multidisciplinary team working and working with others

- We witnessed multidisciplinary team (MDT) working within the accident and emergency department. During our inspection a road traffic collision happened within the local area with injured people attending the ED via the ambulance service. An alert was made to the ED and the correct teams were in place when these patients arrived.
- We observed that there was a medical and nursing team leader within the resuscitation area when required.
- During our inspection we witnessed within the major's treatment area that staff did not work together to assess and plan ongoing care and treatment in a timely way when people were due to move between teams or departments, including referral, discharge and transition.
- Prior to the inspection we were aware that the number of patient handovers from ambulance crews within 15 minutes was below the England average. On the day of our inspection the ambulance service had recently placed a hospital ambulance liaison officer (HALO) into the department to assist with the delayed ambulance handover process.
- The department is meant to hold monthly clinical governance meetings with the EAU department however the last meeting held was in July 2014. We were informed that another meeting took place however no minute of this were recorded.
- Nursing handovers were not comprehensive or thorough, we observed three nurse handovers and found elements of general safety as well as patient-specific information missing from the handover.
- The shift handover was carried out around a whiteboard in the majors department. This area is a busy thorough fare and staff interrupted the handover process to ask questions. Not all staff were involved in the handover process and individual patients were not involved either in the handover of their care.

Seven-day services

- There was a consultant out of hour's service provided via an on call system.
- The emergency department offered all services where required seven days a week.
- We were told by senior staff within the A&E department that external support services are limited out of hours and it often proves difficult at weekends which has an effect on patient discharges and care packages.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke to were knowledgeable about how to support patients who lacked capacity however not all staff were aware of the need to assess whether a patient had a temporary or permanent loss of capacity as outlined in the latest policy issued by the trust.
- We examined the training records which demonstrated that 84% of staff had attended level 1 Mental Capacity Act training and 58% had attended level 3 Mental Capacity Act Training.
- We observed nursing and medical staff gaining consent from patients prior to any care or procedure being carried out. We spoke to people who used the service and one person told us "Everything was explained to me when I was seen by the nurse." We also observed a doctor gain consent from a patient prior to obtaining a blood sample and explain what the samples were going to be used for.

Urgent and emergency services

Are urgent and emergency services caring?

Requires improvement

The A&E department was not always caring. We had concerns during the inspection with how staff treated patients. We observed instances where patients who were very unwell, dying or deceased were not treated with dignity or respect.

The service was very busy on the day of our inspection; as a result patients who were in the department were not always treated or spoken to appropriately. We found that tasks and care were undertaken in a task orientated manner instead of in a caring way. Though we did observe some positive interactions between staff and patients during the inspection.

The majority of patients we spoke with were happy with their care and some could tell us that they were involved in their care. However we identified four patients who had not had their specific care and treatment needs explained to them, they therefore were not aware when they were not receiving appropriate treatment.

Compassionate care

- During the inspection we found that staff did not always treat patients with dignity and respect. We observed poor examples of treating the deceased and dying with respect. Staff at the trust did not follow the trusts policy in respect of the management of deceased patients within the A&E department.This did not respect the dignity of the deceased or demonstrate compassion to the patients and staff in the area.
- We also observed a doctor treating a patient in an undignified manner. In front of the patient and their family the doctor confirmed that no further active treatment was being undertaken and was then heard to say to staff to "get the patient out of here we need the room". This was a very disrespectful way to treat a patient who was nearing the end of their life.
- In another case we observed the care provided to a patient who was being treated in the majors department. This patient had a serious clinical condition which could not be treated. We observed the doctor ask staff if they agreed on the treatment to be provided
- We saw that staff tried to respect the confidentiality required around patients and relatives when communicating ensuring that people's information was protected but the limited areas available within the department due to pressure of demand did not often allow this to happen.
- The trust can be seen to be submitting data for the Friends and Family Test (FFT). FFT is an important feedback tool that supports the principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses. The FFT highlights both good and poor patient experience. Figures demonstrated that the Friends and Family test score for the emergency department was displayed with two results on posters in the public waiting room.
- The friends and family test results displayed on one poster stated a department score of 32.3% and an overall trust score of 1.9%. Another poster on a wall displayed a department score of 39.3% and an overall trust score of 75.4%. This was confusing to anyone reading the posters. The latest results from September 2014 showed that 77% of patients would recommend the A&E to friends or family.
- During the inspection on 23 December we observed an elderly patient within the resuscitation area whose blanket had slipped leaving them naked underneath. The patients curtains were pulled back and people were walking through the department and could see this patient naked. This patient's dignity was not being respected and we had to ask a nurse to assist and protect the patient's dignity and make them comfortable.

Understanding and involvement of patients and those close to them

- We spoke with four people who were patients in the department. Three told us they felt informed about their care. However another patient informed us that they were unsure of what was going on and they were worried. We observed the majority of staff explaining to patients if there was going to be a delay in seeing a doctor, what the reason for that delay was and how long they would have to wait to be seen.
- We found that patients were not clear on what to expect with their treatment and were unclear when treatment required had not been provided. For example we

identified four patients during the inspection who had not received regular observations. The patients were not aware of this and were not involved in the understanding of the need to be regularly observed as part of their treatment.

- We spoke with staff about the services available and did they provide people who use the ED services with further information or offer an opportunity to ask questions about the care and treatment. One member of staff told us that they do not have the time but there are leaflets available within the department for people to take.

Emotional support

- We witnessed staff providing patients and relatives with emotional support whereby staff demonstrated they understood what the impact of treatment had on a person's wellbeing.
- Staff tried to support patients and their relatives as much as they could in the time they had, however, staff were very busy during our inspection and were therefore unable to spend a lot of time with people. Patients and relatives thought that the staff were helpful if they were approached.
- We saw that people's independence had limited respect which inhibited enabled people to manage their own health, care and wellbeing.
- Access to counselling support services was available and staff could arrange for support for patients if they required additional help.
- After a serious incident there were no debrief sessions within the department and no opportunity to discuss an incident or the impact of the incident on staff. Therefore staff did not always receive an appropriate level of emotional support following a serious incident.

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

(for example, to feedback?)

Inadequate

Services were not responsive. People experience unacceptable waits for some services. The department had surges of activity which occurred on a regular and potentially anticipatory basis. The department struggled with space and staffing in coping with capacity issues with surges of activity.

The trust escalation protocol was sufficient, however this was not used in a timely way and the ED does not provide a safe response when demand reached an identified level. For example, patients had to wait above fifteen minutes within the ambulance triage.

There were regular occurrences of ambulances stacking and waiting to handover within the department delaying the ambulance handover. The ED takes a reactive approach in managing these occurrences rather than a pro-active approach and the ambulance service attend the department in support.

However recently the implementation of the Hospital Ambulance Liaison Officer had assisted in improving delays to ambulance wait times. This had been implemented the week prior to our inspection and was yet to be evaluated.

Services were delivered without consideration of people's needs. GP triage and ambulatory care waiting area was located within the majors department. People waiting there could see patients who had sustained trauma or who were unwell. People who were waiting there could be psychologically affected by observing a traumatic case or resuscitation.

Complaints and concerns are handled inappropriately. The ED had a poor compliance with regards to response to complaints, we found that not all were investigated or handled appropriately.

Some patients who had been in ED overnight were not routinely offered drinks or snacks. One person who had been admitted to the department overnight had not been offered food and a drink until transferred to the ward the following day.

Meeting the needs of all people

- The emergency department has an escalation policy which was developed by the management team. We were told the escalation policy was put in place to follow when the department was experiencing long delays in ambulance handovers, patients being transferred to a ward and including a lack of available

beds within the hospital to admit patients. The policy details what steps of implementation to take. For example, extra staff to be moved into the department including porters.

- During periods of demand the department struggled to cope with demand. There was a lack of clear coordination within teams which did not enable the flow through the department to be safely maintained. We started to witness a delay in speciality reviews.
- The department did not coordinate and deliver care which took account of people with complex needs. For example, we saw that the department did not have champions which led on specific areas to facilitate individual's needs including learning disabilities, mental capacity and dementia.
- Despite the recent improvements the department had limited space that restricted growth in line with a growing population for the services that were delivered. For example, the waiting room did not match the size of the rest of the department. The service offered an ambulatory care service and this often overtook the corner of the major's treatment area whereby privacy and dignity could not be respected.
- The GP triage and ambulatory care waiting area which was located within the majors department was not appropriate to meet the needs of those waiting and those receiving treatment in the majors department. This area of the department was busy and meant that people waiting there to be seen could see patients who had sustained trauma or who were unwell. People who were waiting there could be psychologically affected by observing a traumatic case or resuscitation. The privacy and dignity of the patients receiving treatment in those bays was also not respected.
- Staff we spoke with demonstrated an understanding of the need to recognise cultural, social and religious individual needs of patients. However, we did not find documentation available for people to offer advice in different languages.

Access and maintaining flow through the department

- The department operates a triage system of patients presenting to the department either by themselves or via ambulance and are seen in priority dependent on their condition.
- The trust is performing below the England average, 88% in October 2014 being the lowest for the previous five months when targets have not been reached, with regards to handover of patient care from the ambulance crew to the accident and emergency department and there are consistent long ambulance delays with waiting times over thirty minutes.
- There was no internal 'live' electronic system of evaluating and managing the patient flow through the department to assist with bed demand across the hospital.
- We saw a notice advising people that there was currently a one hour wait to see a doctor; however we observed that the actual wait was longer than this for some patients.

Complaints handling (for this service) and learning from feedback

- The A&E department advocates the patient advice and liaison service (PALS) available throughout the hospital.
- There was limited information available for patients on how to make a complaint and how to access the PALS.
- All concerns raised were investigated and there was a centralised recording tool in place to identify any trends emerging. The ED had a poor compliance with regards to response to complaints with 61.7% responded to within the designated timeframe.
- We looked at six complaints and saw that four were analysed at the root cause. We did not review the other two as these were not available to us.
- We asked staff whether they received information about complaints and concerns. They told us that they were not regularly informed about them. They told us that lessons did not seem to be learned and were not discussed with two way feedback.

Are urgent and emergency services well-led?

Inadequate

The leadership within the emergency department was inadequate. The service had been through many changes and turnover of staff was significant enough to cause the leadership to be insufficiently matured to ensure that patient needs and the demand on flow was maintained.

These changes had affected the morale of staff. The workforce were committed and loyal but showed stress related to work overload and staff did not feel respected, valued, supported or appreciated.

There was a lack of clarity about authority to make decisions in relation to the department during busy periods. The top priority for the service local management team was the delivery of the four hour target which had impacted, to a degree, the delivery for quality and safety.

There was not an acceptance of change and staff told us that it took a long while for practices to change for the better and that this was from within the emergency department and trust wide.

We spoke with nurses, health care support workers, reception staff, porters, junior and senior doctors to find out about the culture of the department and found that there was a great sense of team working. However we saw that there was a lack of coordination by the senior nurses when the department came under increasing pressure.

The department managers are aware the challenges to identify and provide good quality care but struggled to deliver the actions required at times against the demand placed on the department and those challenges.

During the inspection we received a whistleblowing concern relating to the culture within the department, specifically relating to potential inaccuracies with the recording of four hour target times and bullying within the department. We followed up with a further inspection on 27 November and found that the concerns raised were unsubstantiated.

Vision and strategy for this service

- Not all staff that we spoke with was knowledgeable on the trust's vision, strategy or journey. They were not always fully aware of the extent of the problems we identified within the department.
- Information was not always available to all staff in different formats about the trust's vision and strategy. There was limited information provided with updates on any changes or amendments to the department's priorities and performance against those priorities.
- The trust had a lack of vision in the promotion of best practice across the emergency department. The future vision of the department was not embedded within the team and was not well described by all members of staff.
- We saw during our inspection that there was a governance framework in place. However the governance framework was not effective in places to support the delivery of the strategy of the service. For example, not all staff identified, contributed to the framework. Ownership of governance within the department was weak. We did not see an action recorded within minutes of decisions against a non-return of audit data.

Public and staff involvement and engagement

- Staff in the emergency department did not feel engaged outside of the department and demonstrated little awareness of the various initiatives taking place across the trust. One member of staff told us that they just didn't have time to get involved in things when they were working.
- Some staff felt that they were not listened to. For example, when they made suggestions to the trust about how to improve the department these were not responded to.
- During our inspection we did not see any information available to people who use the services for participation and involvement so people could get actively engaged so that their views were reflected in the planning and delivery of services provided within the emergency department.

Governance, risk management and quality measurement

- Monthly departmental meetings were held. We were provided with minutes of the previous meetings held over the past two months. We were not provided with assurance that risks are well managed within the department. Managers were aware of some of the issues we identified but there was not a robust time frame to resolve key issues to address each risk. This meant that quality in risk management could not be measured against trust wide risks.
- There was a set agenda for each of these meetings with certain standing items. For example, incidents, complaints, risk, staffing and training. However we found that the risk register for the department had not been updated since our previous inspection in May 2014.

- A quality dashboard was not displayed within the emergency department at Colchester General Hospital. This meant that people who used the service and staff were not aware of the department's performance around the care being received or delivered.
- We spoke with staff about quality indicators and there was a lack of demonstrable knowledge whereby some staff were unable to provide an example of a quality clinical indicator or a performance indicator. This meant that staff were not aware if clinical care provided was of a good quality and measurable against national figures. However the trust provided evidence that these indicators were available to staff in rest areas.

Leadership of service

- The department is led through a senior team of staff consisting of a matron, general manager and clinical director. These staff cover the medicine directorate. There is a lead clinician from the A&E department who liaises with the clinical director on issues relating to A&E.
- The nursing leadership of the team was led by the senior nurses and we saw that nursing teams have time away from working shifts as a whole team for development.
- Staff told us they did not feel supported by the senior executive trust management team. They told us that the nursing leadership in the department was good. When the A&E was under pressure, the department didn't always receive the support and leadership it needed from a trust wide perspective. We corroborated this throughout our inspection and by review of documentation available to us. We found that staff did not receive debriefing sessions following a serious incident nor did they have time to support patients. We received a whistle blowing complaint regarding the culture within the department which we investigated.
- We were told that the capacity of leadership was planned to be improved with the introduction of advanced nurse practitioners.

Innovation, learning and improvement

- We did not see evidence of staff innovation either on an individual or team basis that was put into practice and owned by the department.
- We spoke with a senior manager within the trust about how lessons learned from incidents were disseminated across the trust. They told us that they would expect senior staff to pass this information to the rest of the team, but they said there was no mechanism in place to check that this was happening. This meant that the culture did not centre on the needs and experience of people who use the emergency department services.
- Since our inspection we were informed that the A&E service was unsafe and that patients were at risk of receiving poor care due to a surge in admissions. Therefore were not assured that safety measures remained in place and opted to return to review the concerns raised. At the time of our inspection 1 patient was being bedded in the emergency department. There were twelve patients waiting for a ward or EAU bed to become available. The longest a patient was waiting in the emergency department from arrival was 12 and a half hours. The longest wait from a decision to admit was 9 and a half hours.
- The trust was not meeting the standard required to comply with regulations. We have judged that there has been a major impact on patients who use the service. This is being followed up and we will report on any action when it is complete.

Culture within the department

- Most staff told us that within the department, there was a sense of team working. They thought that the team pulled together in difficult times and supported each other. Some staff, however, told us that they felt under pressure to meet targets and were made to feel as though they had failed to do their job correctly by senior managers within the trust if waiting time targets were not met.
- A senior manager told us that they were aware of the problems with stress in the emergency department, but there were no mechanisms in place to support other than formal routes. This meant that there was not a strong emphasis on promoting the safety and wellbeing of staff.
- Not all emergency department managers were visible during our inspection. Staff told us that they were approachable and encouraged appreciative, supportive relationships among staff.
- We were told by some staff that good will can only last for so long within the department. However, the majority of staff we spoke with told us that the managers were approachable and encouraged a supportive working relationship.

Medical care (including older people's care)

Safe	Inadequate
Effective	Inadequate
Caring	Requires improvement
Responsive	Inadequate
Well-led	Requires improvement
Overall	Inadequate

Information about the service

Our inspection included one day in the medical care service as part of an unannounced responsive inspection due to concerns raised and information received to the Care Quality Commission (CQC). During our inspection we visited the Emergency Assessment Unit (EAU) only. The EAU is designed for 45 inpatient beds for the assessment of patients prior to transfer to a specialist ward or discharge home. There were a further 17 beds that were identified as being for GP triage, where ambulatory patients would be assessed and a decision made about their care. Due to the high pressures faced by the emergency department, at the time of our inspection GP triage was not in progress and instead the 17 beds were being used as inpatient EAU beds.

Summary of findings

Overall, we judged this service as inadequate with, caring and leadership being rated as requires improvement. The EAU was not safe because there was a lack of awareness and reporting of incidents and we were concerned staff could not identify safeguarding concerns. Whilst the unit operated the National Early Warning Score system (NEWS) to recognise the early signs of a patient's condition deteriorating, staff did not respond to it in the correct way. Patients were acutely unwell on the ward and were not being escalated or being cared for in a safe way. These patients could be classified as in need of medical high dependency care. For example patients in the A&E resuscitation department were being stepped down to the ward without any consideration for the impact on the patient the need for additional staff or clinical monitoring. This meant that patients were at significant risk of harm through deterioration of their clinical condition.

The unit was not effective as we identified concerns about staff competency and there were significant concerns with consent and assessment under the Mental Capacity Act which was routinely not undertaken. We also found that clinical procedures had been carried out on patients without consent or best interest's decisions being taken.

Medical care (including older people's care)

Staff aimed to provide a caring service to patients but many interactions we observed were rushed due to how busy the department was which resulted in some staff not being polite and we observed some poor interactions with patients.

As a service EAU was not responsive. This was because the ward regularly closed the GP triage area to make way for more beds; this meant that patients had to go the accident and emergency department which increased their workload and delivery of their service. We found that patients were routinely moved out of hours. Staff had limited awareness in caring for patients with dementia or learning disabilities.

The service was not well led. Staff were unaware of a vision for the service and senior staff were not always involved in making decisions about the service. Whilst most staff spoke highly of local leadership, several told us that they did not always feel well supported which they attributed to the pace of work.

Due to the dependency of the patients in this area, the number of safeguarding concerns the CQC took urgent action in alerting the trust to the issue. The trust took immediate action to address the issues raised and subsequently raised an internal major incident the following day. CQC monitored the implementation of the increased staffing, improved safeguarding and improved flow and capacity through a second unannounced visit and found that action taken by the trust was appropriate to meet the needs of patients in this area. The service had reduced the number of beds to 45 and opened the GP triage area to reduce pressure on the emergency department. However we did not test how effective these changes were and the CQC will revisit in the near future to see the sustainability of improvements which need to be maintained. CQC and partners will continue to monitor this area closely.Following our last inspection new information of concern was received relating to the care patients received on the EAU including information that the bed base had been increased again without sufficient numbers of staff to ensure the safety of patients.

The CQC determined it needed to return to the EAU and undertake a further inspection on 23 December 2014. We found further significant concerns relating to the care of patients on the EAU department and that people experienced significant delays due to ongoing surges in patient demand. The trust was not meeting the standard required to comply with regulations in EAU. We have judged that there has been a major impact on patients who use the service. This is being followed up and we will report on any action when it is complete.

Medical care (including older people's care)

Are medical care services safe?

Inadequate

The Emergency Assessment Unit (EAU) service was not safe. The ward was approximately 100 yards long and was understaffed by nurses given the dependency of the patients admitted to the ward. The ward operated the National Early Warning Score systems (NEWS) but we were not assured that the seriousness of a patient's condition was always recognised or escalated appropriately. For example we observed five patients who scored highly on the NEWS for risk of deterioration, in each case there was routine disregard for the risks associated with the patient's high scores. Safety of deteriorating patients was not prioritised and the risk to deteriorating patients was unacceptable.

We saw that high acuity patients were admitted straight from the emergency department with no protocol in place for their care despite their high medical dependency needs. These patients could be placed in any bed on the unit and meant that no priority was given to their care and this risked the patient's condition deteriorating because appropriate levels of care was not being provided.

The rota detailed that 20% of nursing staff on the unit were agency. We also found that staffing levels were lower at night though the unit remained very busy with seriously unwell patients. The unit contains 45 beds for EAU and an additional17 beds for GP Triage however due to capacity and flow issues all beds were used for inpatients. Staffing levels were not amended to reflect changing dependency of patients or busy days where attendance rates were high

Whilst we established that staff had access to safeguarding training we were concerned that staff did not have the necessary skills to identify safeguarding concerns and that as a consequence which meant that patients were at risk. This is because we identified three incidents during our inspection that should have been considered a safeguarding concern but had not been identified or referred by staff on the unit.

There was a lack of awareness of reporting and learning from incidents and there was no safety thermometer displayed. There were poor infection control practices, we saw numerous occasions where staff did not wash their hands or failed to changes gloves when attending patients. We found records to be incomplete with some assessments and paperwork not fully completed. This meant that safety systems, processes and standard operating procedures were not fit for purpose.

Incidents

- All staff we spoke to stated that they were encouraged to report incidents using an electronic incident reporting system. Four member s of staff that we spoke with told us that they had not received feedback regarding incidents or change in practice.
- One member of staff told us they did not report incidents with staffing as they received no feedback and they believed that reporting an incident had limited value.
- During the inspection we observed a patient be resuscitated after going into cardiac arrest. This person we later identified, through examining their medical records, had a do not attempt cardio pulmonary resuscitation (DNACPR) order in place. Staff had not checked the patients' status prior to the resuscitation taking place nor had the policy on cancelling a DNACPR order been followed. However the trust reported that this had been invalidated on this admission and therefore staff acted appropriately but this was not recorded in the medical records we reviewed. This event should be classed as a serious incident and investigated appropriately. It should have been reported as a safeguarding concern. We asked staff should report such an incident but they were unsure if it warranted reporting. We escalated this to the Chief Executive and Director of Nursing to ensure this was appropriately reported and investigated.
- There had been one recent never event in relation to the medical directorate. A never event is classified as an incident that should never happen. We spoke with some senior staff who were aware of learning from this incident, although other staff we spoke with were unaware. Senior staff, both nursing and medical, told us that there was a lack of learning from incidents.
- The service did not hold any Mortality and Morbidity meetings between June and September 2014. We were informed that the meetings were being held monthly and were attended by the multidisciplinary team. All deaths within the department were presented by a junior doctor and discussed. Although we asked for the minutes of the meetings held in September and October

these had not been written up and were not available. We were not assured following discussions with staff that there was a clear understanding of mortality or morbidity risks on the EAU.
- We asked staff on the department what feedback or learning was shared from mortality and morbidity however of the five staff we spoke with none were aware of any discussions around mortality in relation to the EAU.

Safety thermometer

- Safety thermometer data was not displayed within the emergency assessment unit. Furthermore, some staff we spoke with did not know what the safety thermometer was or what it indicated.
- Safety crosses were displayed on information boards on the ward. This data indicated the number of harm free days between the months of July and October 2014. The data showed the unit was 100% incident free in areas such as incidences of C difficile, MRSA, pressure ulcers and missed doses of medication. The data demonstrated the number of complaints received by the unit and the number of falls by patients on the unit.

Cleanliness, infection control and hygiene

- The EAU lacked storage space which meant the corridors were not free of equipment. We saw that some equipment had stickers to indicate they had been cleaned but this was not consistent with all equipment so we could not be sure that all equipment had been cleaned.
- There was hand washing facilities and hand sanitising gels available throughout the EAU though the one dispenser at the entrance of the ward was empty. Information was available to remind staff and visitors of the importance of good hand hygiene, so as to minimise the risk of infection.
- We saw numerous instances during our inspection of poor hand hygiene, despite the EAU's audit of hand hygiene compliance being 100%. For example, we saw nurses carry out tasks between several patients with the same pair of gloves and apron on. In one instance we saw a nurse wearing gloves whilst checking some paperwork, adjust an alarm on a monitor, then give another patient some intravenous medication, with the same gloves on. We observed they then removed the gloves and attended to another patient without washing their hands.
- We observed nurses and care assistants going from patient to patient carrying out tasks such as taking blood pressures, temperatures and helping patients with drinks without washing or sanitising their hands between each patient.
- We observed an empty bed being made. The hand held control to use the electronic bed was on the floor and was not cleaned so posed an infection risk.
- The EAU had an infection control board which outlined the area's monthly performance which included urinary catheter care and the prevention of C difficile. We found the information on display was dated December 2013.
- 'Bare below the elbow' policies were adhered to by staff. We saw no staff wearing inappropriate jewellery.
- Patients and their relatives we spoke with said that the EAU was regularly and thoroughly cleaned. People spoken with commented that it was "extremely clean".
- During our inspection on 23 December 2014 we observed staff leaving the EAU and entering with not using the hand hygiene available.
- Staff moved around the ward freely with not washing hands between bays and answering the telephone.
- We observed an intravenous line ready for patient administration being placed on top of notes in the corridor whilst the nurse spoke with another nurse. We were therefore not assured that improvements had been made since our inspection on 12 November 2014.

Environment and equipment

- The bays in EAU were set alongside a very long corridor and the layout made it difficult to observe patients unless a member of staff was physically in the bay or side room. There were insufficient areas for staff to write up notes. We saw staff leaning on machines to write their notes.
- We saw that equipment had been checked and tested regularly in line with manufactures and national requirement.
- There were 3 resuscitation trollies on the unit and we found them to be checked and correct.

Medicines

- The intravenous fluid store was at one end of the ward near the entrance to the ward. It was protected by a keypad lock and had a 'staff only' notice on the door. On the day of our inspection the door was unlocked and therefore medicines were not secure.
- We looked at four patient's medicine charts. We saw that essential information such as the patient's name

and any allergies were correctly recorded. Pre-printed, bar-coded labels were used on all records. The patient's name and date of birth was in very small writing, which meant that there was a risk of errors as the writing was difficult to see.

- We saw that medicines had been prescribed correctly, any changes had been clearly made, for example, discontinued medicines had been crossed through and any changes had been rewritten correctly. Medicines given had been signed for. If they were not given there was a reason recorded.
- We observed that patients who had IV's did not have their drips checked or changed regularly. This was linked to the lack of time staff had to provide care to patients. However it meant that the administration of IV medicines was not actively monitored.

Records

- We examined the records of 14 patients during our inspection of this ward. Nursing notes were generally kept in a trolley outside each bay and were not locked. We saw open records on trolleys in the corridor which were easily accessible to the public. This meant that patient confidential information was not secure.
- Admission checklists and patient safety checks were inconsistently completed and risks around falls, venous thromboembolisms, malnutrition universal screening tool (MUST) score and moving and handling were not always assessed.
- We were told that certain assessments had to be undertaken within 24 hours. These assessments related to bed rail assessments, body maps, nutritional assessments and skin assessments. We saw a nursing score card which indicated the unit had 100% for full screening. However when we examined eight patient records against this measure we found that six had not been fully completed.
- Staff were using the visual infusion phlebitis score (VIPS) to monitor cannula insertion sites. However staff did not always take action when the score indicated the cannula should be removed. This meant that patients were at risk of developing complications associated with the insertion of cannulas and were placed at greater risk of infection.
- We saw in four records that fluid charts were not fully completed though patients were receiving intravenous fluids and had urinary catheters in place. We observed one member of staff filling in a fluid chart for the preceding 6 hours at a single time. We were concerned that fluid charts were not an accurate reflection of people's fluid balance.
- Two members of staff expressed their concerns to us and informed us that they were trying to focus on care, therefore this meant that paperwork was not completed.

Safeguarding

- We saw that safeguarding information was available on the ward and three staff members we spoke with could describe their responsibilities with regards safeguarding vulnerable patients.
- Staff told us they had completed safeguarding training, we examined training records which evidenced that safeguarding formed part of their mandatory training.
- However, we identified three incidents during our inspection that should have been considered a safeguarding concern but had not been identified or referred by staff on the unit. One patient had a 'Wanderguard' bracelet placed on their wrist to alert staff of the risk of their movement around the ward. We found that no mental capacity assessment or Deprivation of Liberty Safeguard assessment had been undertaken on this patient.
- A second patient we identified had been prescribed administered sedative calming medicines without a clear diagnosis as to why these were required. Staff informed us that this was due to challenging behaviour from the patient. However no mental capacity assessment or Deprivation of Liberty Safeguard assessment had been undertaken on this patient. Therefore this patient had been restrained through the use of medicines without consent.
- A third patient we identified had been recorded in the records as being confused and that consent to a procedure could not be obtained. The note in the records recommended proceeding with the invasive procedure. No mental capacity assessment had been undertaken, consent had not been received. Therefore the procedure had been undertaken without legal consent from the patient or their advocate. Also the staff did not follow the trust's consent policy.

- During the inspection we were informed of an event where a patient was physically restrained by staff so that bloods could be taken from a patient. However we did not observe this incident and we were therefore unable to corroborate whether or not this event occurred.
- We brought this to the attention of senior management at the time of our inspection who referred these incidents to the proper authorities. We were concerned that staff did not have the necessary skills to identify safeguarding concerns and that as a consequence which meant that patients were at risk.

Mandatory training

- The staff we spoke with told us they had completed mandatory training, mostly via e-learning and were up to date. Senior nursing staff reported that it was a challenge to release staff to enable them to complete their training, even though most of it was done on line.
- Six members of staff we spoke with reported some difficulties in accessing training due to work pressures and demand of the service which meant that they could not be released for training.
- We reviewed the training data submitted by the trust and found that on average 70% of all staff had received mandatory training, with support staff recorded as attending more training than nursing or medical staff. At November 2014 51% of all staff in EAU had received infection control training, only 38% off doctors had received infection control training.
- We found that 79% of all staff had received mental capacity act training at level 1 and 44% had received level 3 training. Of the medical staff 60% had received level 1 training, 33% level 2 training and 40% had received level 3 training on the Mental Capacity Act 2005.

Assessing and responding to patient risk

- Patients were monitored using recognised observational tools and some had electronic monitoring in place. The frequency of observations was dependent on the acuity of the patient. Alarms were set on monitoring equipment to alert any changes in the patient's condition.
- The unit used the National Early Warning Score (NEWS). This was a mechanism for calculating certain indicators whether or not a patient was deteriorating clinically, and if so, whether further or new intervention was required. A higher score triggered further intervention from a senior nurse or doctor to ensure that any changes in a patient's status were managed immediately.
- We looked at one patient's record that had a high NEWS of between 7-12 since their admission 24 hours earlier. The patient had been reviewed by a doctor when their NEWS score was high and they were required to have hourly observations. Records indicated that during one ten hour period the observations were only carried out three times. Therefore this patient was at risk of deteriorating without being appropriately monitored.
- We saw a further five patients with high NEWS. Junior and senior staff we spoke with told us that the high score "was normal for the patient" due to their underlying medical condition and that a high score was not always escalated. We found that the rationale for this course of action was not clearly recorded in four sets of notes we looked at and we were concerned that patients were not being monitored correctly or risk assessed.
- For example a patient was admitted to the A&E department in June however due to clinical factors their condition deteriorated within A&E. The patient was transferred to the EAU at 11.10 in a critical state without the correct interventions in place or an appropriate bed available for close observation and monitoring.
- Patients with complex and higher dependencies were admitted to the next available bed rather than to a specific area on the ward. This meant that staff were caring for very dependant patients alongside others who were not so dependant. This meant that patients were not appropriately monitored because care plans and staffing levels were not appropriately adjusted to meet the high clinical dependency of patients. This could place patients at risk of harm.
- At the time of our inspection a patient with a high NEWS was admitted from the resuscitation area of the emergency department. We saw that this patient was admitted to the next available bed irrespective of where that was on the ward. This meant that patients of differing acuity were cared for in the same area. This meant that patients were not appropriately monitored because care plans and staffing levels were not appropriately adjusted to meet the high clinical dependency of patients. This could place patients at risk of harm or death.

- We examined this patient's records and saw that the doctor's notes stated that the patient's fluid intake and urine output should be measured closely. Although it was recorded during part of the day of their admission however there were no recordings after 8pm until we reviewed the notes at approximately 10am. There was no indication in the notes that the fluid balance should be discontinued. We asked one of the nurses for an explanation. However they could not explain why the NEWS was not being done according to the patients need, why high scores were not escalated, or why the fluid balance was not being recorded as the doctor had instructed. This patient was placed at risk of harm through receipt of poor care.
- There was an outreach team that provided support for the management of deteriorating patients on the wards. This service was available seven days a week. Staff we spoke with were complimentary about the service that was offered by the outreach team who were described as very responsive when they assessed and offered advice to the staff on any patient that may be causing concern. However we were not assured, based on our inspection findings, that this team was being used effectively to support deteriorating patients.

Nursing staffing

- We found that on the day of the inspection the number of staff on was not sufficient because staffing had not been calculated to reflect the high clinical dependency of patients or the environment of the ward. The safer staffing tool had been used to assess how many nurses would be required to staff the ward but the level of dependency had not been taken into account. Staffing levels were also reduced at night however the dependency of patients did not reduce during this time. Therefore patients did not receive appropriate care, for example changing and monitoring of IV medicines in a timely way, because there was a shortage of nursing and support staff to meet the clinical needs of patients.
- We saw the unit was staffed by 12 registered nurses and 5 health care assistants during the day and 9 registered nurses and 4 health care assistants at night. When asked the senior staff and senior manager could not explain why staffing levels were lower at night when the same number of high dependency patients were on the ward.
- We had serious concerns about the change to lower staffing at night on this ward. The patient clinical need and high dependency did not change at night and therefore patients may have been at immediate risk of harm at night as a result of lower staff numbers. Staff we spoke with told us that night shifts remained as busy as day shifts.
- We had serious concerns that staffing levels did not reflect patient conditions. We reviewed six patients on the unit required high dependency care classified by the Intensive Care society as Level 1 or Level 2 care. Staffing levels are set as a guideline in line with these standards with one staff member per two level 2 patients and one staff member per three level 1 patients. However the trust had not factored this into rota and therefore nurse staffing levels were not sufficient and placed people at risk of harm through deterioration.
- We were told an acuity tool was not regularly used to determine the number of staff required to care for patients of varying levels of acuity. The Matron told us there had been a recent formal staffing review which had recommended an increase of staffing levels during both the day and night and the review had recommended that staffing should be the same 24 hours a day.
- There were 9 vacancies for registered nurses on the ward though we were told despite rolling recruitment it was difficult to attract and employ qualified experienced nurses to work in the EAU.
- 20% of the nursing staff on the EAU rota were from an agency, although many of the nurses were well known as they worked regularly, some were not. A doctor told us, "Nursing staffing is a problem. We need a stable team. There is a lot of agency staff. I do worry that there are some hours when I wonder if it's safe."
- Following this inspection we received information from the trust that they were working to ensure that immediate measures were implemented to review and improve staffing levels for registered nurses and support staff on EAU.
- During our inspection on 23 December 2014 we established that EAU had vacancies for 14 WTE band 5 staff nurses at the time of our inspection which is an increase from nine since our inspection on 12 November 2014.
- From rotas we saw that actual staffing was not always the same as planned staffing. On Monday the 15th, Wednesday 17th and Friday 19th December the actual staffing was only 75% of the staffing planned but there was no corresponding decrease in the number of patients cared for.

Medical care (including older people's care)

- Staff we spoke with told us that they had completed an acuity tool in November which informed the need for further staff to safely manage the acuity of patients above a bed base of 30 (with additional triage trolleys). However, due to vacancies and the high throughput of patients this was not being met. Agency staff were being used to increase staff numbers whilst recruitment continued.
- Senior staff tod us that they did not always have the number of staff they needed to care for people safely.
- We saw an acuity tool completed in November. Staff told us that the acuity of patients fluctuated frequently and that the trend was for dependency to increase but no further acuity or dependency tool had been completed.
- During our inspection we stood in one bay with three patients and no staff came in for 20 minutes. When a member of staff did enter the bay, they picked up some linen and left without engaging the patients.
- We were therefore not assured that there was a sufficient number of staff available to meet the requirements of the rota for a busy acute medical unit and this placed patients were not safeguarded from the risk of harm.

Medical staffing

- There were six Consultant Physicians, which included 2 locums and a variety of other doctors, both junior and specialist Registrars on the rota. There was a Consultant on duty every day, including weekends and bank holidays from 8am until 10pm.
- During the night, there were two specialist registrars and two junior doctors in the hospital. However, due to workload, the juniors were usually based in the EAU. All the doctors worked between the EAU and A&E but reviewed patients who needed a medical opinion in A&E and/or required admission to the EAU.
- We observed a medical staff handovers during our inspection. Communication between staff and the health care professionals was effective. We found the handover discussed and included information regarding risks and concerns relating to each patient. However the recognition of severity of patient conditions including NEWS was not always clear. Discharge plans were also discussed as well as any issues that required follow-up.

Major incident awareness and training

- There was a major incident policy in place for the hospital and business continuity plans in the event of a major incident being called.
- Following our inspection the trust called a major incident in relation to hospital capacity. This decision was taken by the trust to enable support regimes to openly support a driving improvement in care being received by patients in the hospital.

Are medical care services effective?

Inadequate 

The EAU was not effective. We had serious concerns regarding how consent for procedures and treatment was taken from patients or those who advocate for patients. We saw records that showed interventions were carried out without consent and without following proper procedures.

Whilst staff had access to training through an e-learning module they had limited understanding of the Mental Capacity Act 2005 (MCA). We found that MCA assessments were not routinely completed prior to giving treatment or undertaking procedures. We found four cases where people could not consent, no best interest decisions were taken yet treatment or procedures were undertaken. In one case a patient was receiving one to one care from a staff member and had a 'Wanderguard' bracelet on. No consideration or applications to authorise a deprivation of liberty had been made nor could the service demonstrate it was using the Deprivation of Liberty Safeguards. We raised these concerns urgently with senior managers at the time of our inspection.

We found that intravenous fluids were not well monitored and found two patients who were nil by mouth but whose intravenous fluids were running too slow. We saw that some agency staff were had limited induction and no competency assessments before carrying out intravenous therapy. We saw positive examples of multidisciplinary working and seven day services on the unit.

There were significant barriers in the working relationship between the A&E department and the EAU. However the

flow of the two departments should be a coordinated approach to ensure patient safety however we found that the two services on the day of inspection did not communicate effectively

The information needed to plan and deliver effective care to people is not available at the right time. The unit did not have effective procedures in place to recognise when a patient might be at the end of their life. Whilst we saw two 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms which had been completed appropriately. Staff were not aware of all patients on the unit who were not for resuscitation.

Evidence-based care and treatment

- The medical department used a combination of NICE, and Royal College guidelines to determine the treatment they provided. Local policies were written in line with this and were updated every two years, or if national guidance changed.
- There were specific care pathways for certain conditions, in order to standardise the care given. Examples included sepsis and acute coronary syndrome.
- We were told that junior doctors were encouraged to undertake a clinical audit to assess how guidelines were adhered to.
- However, where completed audits identified areas for improvement in clinical effectiveness and outcomes for patients, it was unclear whether there were action plans in place to improve effectiveness and complete the audit cycle.
- There was an endoscopy list every morning, seven days a week, to deal with patients who may have had an upper gastro-intestinal (GI) bleed. However, there was no formal on call system in place to deal with patients who may have severe GI bleed outside of normal working hours. One of the senior doctors confirmed to us that there was lack of clarity around dealing with such a medical emergency out of hours. Another staff member confirmed there is no clear process for out of hours care. A response we viewed dated 05 August 2014 to the clinical director from staff stated, 'currently we are unable to provide a 24/7 bleeder on call service.' Therefore this service is not being provided in accordance with Clinical guideline 141 issued by the National Institute for Health and Care Excellence (NICE) on Acute upper gastrointestinal bleeding: management.
- The trust scored a C rating in the Sentinel Stroke National Audit Programme. This was in line with the England average.

Pain relief

- There was a pain team within the hospital who dealt with patients with both acute and chronic pain. We saw that analgesia (pain relief medicines,) when prescribed were given as directed. However, we did not see any recognised pain tools being used to objectively assess patient's pain and response to analgesia.
- We saw from records that patients were given appropriate pain relief in line with the prescription.

Nutrition and hydration

- Although we did not observe meals being served during our inspection, we saw that patients had a choice of meals, which they could choose from a menu. There was a limited selection of sandwiches available out of hours. We saw that patients who were able to drink had drinks within reach.
- We saw two patients that required intravenous fluids as they were nil by mouth. During our observation the intravenous fluids ran out and there was a delay of up to 50 minutes to replace them.
- Two further sets of notes we reviewed showed that intravenous fluids were running slower than they were prescribed. For one patient this was by 8 hours. We were concerned that patients were not receiving the intravenous fluids at the rate prescribed which put patients at risk of dehydration.
- One patient admitted from the resuscitation room had intravenous fluids running quickly. The member of staff responsible for the patient was unaware of the fluids until we brought it to their attention despite a handover being given.

Patient outcomes

- The trust was part of the 'Keogh review' in 2012 due to the high reported levels of mortality. The hospital continues to have an elevated Standardised Hospital Mortality Indicator (SHMI). We examined the action plans submitted by the trust in response to their increased mortality levels. These were still being worked through and not all identified actions from the reviews undertaken were being implemented.

- The current mortality is around the mean average for England. However local monitoring of trends around mortality is not being routinely undertaken in EAU and therefore effective strategies to improve mortality are not in place.

Competent staff

- There was an induction programme for new staff. This included both a trust wide induction and local indication. There was one designed for permanent staff and another, shorter one for flexible workers, such as bank and agency staff. The Matron told us that they were working hard to ensure that new staff had a thorough induction and were supported when they were new in post.
- There were work books in place to ensure that staff had completed their clinical competencies, for example, blood transfusion, use of electronic IV pumps. We did not see any completed workbooks during our inspection.
- The agency staff were all employed from agencies that were known and approved by the Trust. The agencies undertook to ensure their staff had completed basic training, for example moving and handling and certain clinical competencies, for example, administration of intravenous (IV) medicines. Although the Trust permitted agency nurses to administer IV medicines, they did not allow them to commence blood transfusions, but did allow them to care for a patient receiving a blood transfusion. This is an anomalous and atypical situation with regards to administration of IV medicines.
- We spoke with an agency member of staff. They told us that it was their first day but they had not received any induction. We saw that they carried out intravenous therapy even though it was their first day. The member of staff told us that the unit allowed them to carry out this skill if they felt confident. This meant that the testing of staff competencies on IV's was not effective.
- A member of the management team told us that the department was behind with completing staff appraisals. The most recent Trust report stated that the completion rate for the year was 45%. The number of appraisals on the unit at the time of our inspection was 54%. We spoke with five members of staff about appraisals. Three said that they had not received appraisal. One told us that their last appraisal was more than a year ago.
- None of the staff we spoke with had received clinical supervision or support.
- Doctors reported appraisal and revalidation taking place according to General Medical Council guidelines. Junior doctors were appraised in line with their Deanery.
- Many of the medical staff working on the ward were locums. Because of the number of vacancies and locum staff, there was an increased risk that some of the short-term locums may not have the skills and competencies to meet people's needs.
- All clinical staff reported to us that the Trust supported further development, for example, advanced life support courses for senior staff, or higher degrees.
- The EAU did not hold staff meetings. We were told that there had been few attendees at previous meetings. Essential information was provided attached to staff's payslip as a method of communication.
- The junior doctors had a hand over twice per day. The main focus of the handover was patient's treatment and progress; however, they reported that it was also a format for general information to be exchanged.

Multidisciplinary working

- There was clear evidence of effective multidisciplinary team (MDT) working on the EAU. There was a team of regular physiotherapists, occupational therapists and other allied health professionals. They attended ward rounds and worked with the patient care coordinators and rapid discharge action team (RDAT) to facilitate patients' prompt and safe discharge home, or transfer to an appropriate in patient ward. MDT meetings were held around the patient during the daily Consultant's ward rounds.
- We observed a meeting which were attended by the MDT which covered a variety of topics for example, discharge, new referrals, risk issues and complex case discussions. We saw that medical, nursing teams and therapists worked well with other specialities to provide good multi-disciplinary care.
- There was evidence that the Trust worked with external agencies such as the local authority and commissioners when planning discharges for patients.
- Speech and Language therapists visited the unit when required. They were not part of the MDT formally.

Medical care (including older people's care)

Seven-day services

- There was a medical presence on the ward seven days per week, 24 hours a day. Consultants ward rounds took place daily, even at weekends and on bank holidays. There were consultants present in the EAU during the day, 8am to 10pm and an on call service out of hours.
- Consultants worked on rotation and were responsible for ensuring the unit had adequate clinical cover from junior doctors at all times when a consultant was not on duty on the unit.
- Patients were seen by allied health professionals during week days. Nursing staff followed care plans at weekends to continue rehabilitation therapy with patients.
- Physiotherapists who gave respiratory support were on call 24 hours.
- Most facilities were available out of hours, this included physiotherapists, radiographers, radiologists and pharmacy service, all available at night and weekends.
- The Trust had an outreach team, which was based from the Intensive Care Unit (ICU.) An outreach team is a recommendation jointly of the Faculty of Intensive Care Medicine and Intensive Care Society core standards. The team were used within the hospital to provide advice and guidance for staff caring for patients in other wards who may be showing signs of deterioration. The team worked seven days a week.

Access to information

- We saw that medical records were available to staff caring for patients which meant continuity of patient care. We were told that test results were available quickly and were readily available to review.
- There were large white boards which contained patient details on display in the main ward. The boards were situated in the main corridor and appeared to be the main hub of the ward. However, they were they were in public view, which could have breached patient confidentiality as patients names and clinical status and details were displayed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were able to give their verbal or written consent to treatment when they were mentally and physically able. However, none of the six staff we spoke with about this, had received training on the Mental Capacity Act 2005, including provisions for depriving someone of their liberty in their best interests. This meant that staff may not have acted in accordance with the law when treating a patient who did not have capacity to consent because of, for example, unconsciousness, impaired cognitive function or in an emergency.
- We reviewed 8 sets of notes and found that the mental capacity assessment had not been completed. We identified two patients who were described as 'confused' but had no assessment completed despite one patient being identified as having capacity issues. Furthermore, these patients had been treated without a best interest's decision being made. One patient's records indicated that a doctor was unable to gain consent but attempted the procedure regardless. Another patient had received medication that can be used to reduce agitation but also has sedative qualities. This meant we could not be sure that patients gave their consent, or the proper procedures followed to make best interests decisions.
- We saw a further patient had had a 'wanderguard' fitted to alert staff to them leaving the unit. However, no mental capacity assessment or best interest's decision had been recorded in the absence of their consent.
- We saw two 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms. These were signed and dated by both the patient and the attending doctor. There was a reason recorded on the form why the DNACPR was in place.
- The trust did not have effective procedures in place to recognise when a patient might be at the end of their life. We looked at the records of two people. On one occasion we asked about the resuscitation status of a patient. Members of staff caring for this patient were not aware, and thought the patient was for full resuscitation but after some searching they confirmed this patient was not for resuscitation.
- We observed that a patient had suffered a cardiac arrest. An emergency call was put out and the patient received cardiopulmonary resuscitation. We later discovered there was a do not resuscitate order in the patient's notes. The outreach nurse told us this was not valid as it was written in March 2014. This had not been reviewed with the patient or their family on this admission despite the patient being very unwell.

Are medical care services caring?

Medical care (including older people's care)

Requires improvement

We found that the service was not always caring and that improvements were required. We observed that patients were not always treated with dignity or respect as they were asked to wait to receive care due to the unit being busy. We saw several negative interactions were staff did not display a caring attitude. The highest reported area of complaints on the emergency medicine service over the previous six months showed that staff attitude and communication was the primary complaint from patients.

The unit was exceptionally busy during our inspection and due to the level of work required of staff we observed that staff were observed to be blunt and short with patients due to the pressures of the department which meant that the staff were focused on the task and not on the patient. Of the 13 patients and two relatives we spoke with a majority told us that they had received good care on the unit and that they had been involved with their care. However the NHS Friends and Family test results were generally positive but the response rate was low at 17%.

We examined the notes of 15 patients who were receiving treatment and found that in eight cases that the patient had not been involved in the decision making around their care or treatment. The medical teams have therefore not given the patients time to respond or help them to understand the treatment they would receive. In four cases patients required advocacy support to help with decision making for treatment, yet no advocacy support was provided in relation to treatment decisions.

Compassionate care

- The trust took part in the 'Family and Friends' test, but although the results were favourable with a score of 86, the overall response rates for the trust were poor at 17% of responses received. There was no analysis of feedback, or any trend analysis to drive practice improvements.
- Throughout our inspection, we witnessed most patients being treated with kindness and compassion. On the day of our inspection, all 62 beds on the EAU were full, which was usual. It was evident that the patients were very dependant and had high acuity. There was a continuous rapid turnover. All staff we spoke with confirmed this and that they were always tired due to the pressure of work.
- We observed that call bells in the unit were ringing constantly. Several times during our inspection we answered calls from patients who sounded distressed and required help to keep them calm whilst a staff member was on their way. We brought this immediately to the attention of nursing staff who responded appropriately.
- Patients and their relatives who we spoke with told us that staff were kind to them. One told us, "Most of them are really nice, but they are so busy. I have been here two days and they say they're going to come back, but they don't. It's not their fault."
- We saw that comfort rounds (intentional rounding) were undertaken. The trust information leaflets state that this should be undertaken every two hours. However, from the four sets of nursing notes we looked at, these were done sporadically and consisted of ticking a box. One nurse told us, "It's another thing we have to try and do." This process was not completed well and did not enquire that patients received compassionate care.
- We saw a number of negative staff interactions. We saw a member of staff walk into a side room where a patient was shouting for help. The member of staff said "what? It is all sorted." When the patient replied it wasn't, the member of staff said "yes it is, the nurse will come and do it" and then abruptly left.
- We saw frequent interactions with patients that were short and conveyed limited information. This appeared to be because of the busyness of the unit. For example, a nurse completed neurological observations and said "Hello, [name], hello". When the patient opened their eyes the nurse completed the chart and then walked off without further interaction.
- We saw that doctors introduced themselves appropriately and that curtains were drawn to maintain patient dignity. Discussions between doctors, nurses and patients were carried out discreetly and sensitively behind the curtain, so as to maintain privacy where possible.

Understanding and involvement of patients and those close to them

- We spoke with 13 patients and two relatives. They spoke positively about their care and treatment and were

treated with dignity and respect. They also reported that they were included and involved in making decisions about their care and treatment. Three people specifically told us 'staff explained everything.'
- Patients and relatives we spoke with said they had been given the opportunity to speak with the consultant or the doctors looking after them. Most patients knew that they had a small team of nurses allocated to their care. One told us, "I have been kept informed of what is happening to me."
- One patient said that they were unaware of their planned care and treatment, or the arrangements for their discharge home.

Emotional support

- We did not see any evidence that patients' emotional wellbeing, including anxiety and depression were assessed on admission. We saw one patient's record whose diagnosis was 'confusion.' However no vulnerable adult or mental capacity assessment had been made. Therefore, it was unclear if appropriate referrals for specialist support were made, where required.
- When there was a death or a distressing event on the EAU, staff told us there were no sessions held to enable debriefing and support. There was no counselling in place for bereaved relatives and staff were unsure how to refer to these services.
- Clinical Nurse Specialists (CNS) were available to offer advice and support to patients and relatives about diagnosis and treatments within the hospital.
- The hospital did have a chaplaincy service, but one of the senior nurses told us chaplains were not utilised as a routine to support staff and patients, unless patients specifically requested a visit.

Are medical care services responsive?

Inadequate

The EAU was note responsive. The unit was made up of 45 inpatient beds and 17 beds in a GP triage area. Over the previous six month period the trust had regularly closed the GP triage area to allow for more inpatient beds which meant that patients were diverted to the emergency department for treatment. This delayed the patient's treatment and subsequently impacted on the service delivery of the emergency department.

The EAU was providing care to patients who would classify as high dependency patients at Level 1 or Level 2 in line with Intensive Care Society Standards. The EAU was not set up for people with such complex needs. The lack of high dependency support on EAU or in the hospital meant that the service could not always meet people's high dependency needs.

We saw that there was regular movement of patients throughout the day and night to transfer patients to specialty wards and to make space available for new admissions. Over a five day period 142 patients were transferred out of the EAU between the hours of 8pm and 8am. More patients were moved at night than during the day. There was 223 occasions over the last six months when patients stayed on the unit for more than 72 hours which meant that the patients did not always receive care under their required speciality in a timely way.

Staff we spoke with were not aware of receiving feedback from complaints or how practice had changed following a complaint. Over the past six months there had been an increase in the number of complaints received by the service. Lessons learnt from complaints could not be evidenced or demonstrated by the service. Concerns and complaints were not leading to improvements in the quality of care.

Discharges from the unit were supported by specialist staff who ensured all information was available to manage the discharge. On the unit there was a good range of leaflets available on various conditions for patients to read.

Service planning and delivery to meet the needs of local people

- Whilst there had been an identified need for a GP triage service, this was regularly suspended and the area was used for inpatient beds. Therefore the importance and function of the GP triage service was placed as an additional pressure on the A&E service and was not effective.
- The EAU opened additional beds in a reactionary manner, sometimes at night, to address demand and

pressure on the emergency department. This was done without adequate consideration of staffing numbers, skill mix and availability of beds further through the hospital system.

- Out of hours (Between 8am and 8pm Monday to Friday and on Saturday and Sunday) the hospital was led by the Clinical Site Managers with input from the outreach, medical and surgical teams and involvement from the junior doctors. There were suitable arrangements for out-of-hours support from other services, such as physiotherapy, imaging and pharmacy.
- The trust has a 14 bedded intensive care unit. However no medical high dependency care service. Medical high dependency is incorporated into the intensive care service. The EAU was providing care to patients who would classify as high dependency patients at Level 1 or Level 2 in line with Intensive Care Society Standards.
- We identified patients who were receiving non-invasive ventilation and others who required observation due to the potential for acute deterioration to the point of needing advanced respiratory support. These patients would be classed as Level 2 care patients. The EAU was not set up for people with such complex needs. The lack of high dependency support on EAU or in the hospital meant that the service could not meet people's needs.

Access and flow

- The ward had 62 beds in bays and 10 side rooms. We were told 17 beds were for GP triage but that when the hospital was busy these beds were used as inpatient beds. At the time of our inspection all beds were being used as inpatient beds with GP triage patients having to attend A&E.
- It was Trust policy that bed moves were to be avoided after 9pm. However staff reported that patients were often transferred around the hospital at night to allow for admissions from A&E. We reviewed data provided by the trust which showed that for a five day period between 10 and 15 November 2014 that 142 patients were transferred out of the EAU between the hours of 8pm and 8am which is higher than expected when compared with 81 transfers between 8am and 8pm for the same period. Therefore flow was not responsive.
- EAU is an acute ward with a recommended length of stay of up to 72 hours with the end result being discharged or admitted to a service specialty ward. The trust provided us with data which showed that between 01 April and 31 October 2014 that a total of 223 patients, or on average 32 patients per month, had been admitted and stayed on the EAU for more than 72 hours which is not in line with NHS recommendations.
- We saw that the unit regularly admitted very unwell patients with high NEWS scores. We asked staff if there was a policy, procedure or pathway for identifying and managing the transfer of acutely unwell patients, from the emergency department resuscitation room or majors area, to the EAU and were told there was not.
- Consultant led ward rounds were undertaken at least once a day. Physiotherapists, occupational therapists (OTs), nursing staff and junior doctors attended. Estimated discharge dates were identified as soon as possible after a patient was admitted and these were displayed on whiteboards, discussed at daily board rounds and amended, as necessary through we saw that not all patients discharge dates were updated or accurately reflected their clinical conditions and treatment plans.
- There were three Patient Care Coordinators in post. They were senior nurses whose role it was to ensure that all patients were seen by a consultant daily, tests and their results were available rapidly and to ensure that discharges were prompt and safe. They worked closely with all the doctors and nurses and the Rapid Discharge Action Team (RDAT) which was made up of a nurse, Occupational Therapist and Physiotherapist.
- The Patient Care Coordinators were ensured that the patients were seen by a consultant daily, any treatment plans were carried out by the junior doctors and liaison with the MDT. This assisted in ensuring patients were investigated, treated, transferred to another in patient ward or discharged swiftly.

Meeting people's individual needs

- Staff told us that there were translation services available but that they were seldom used as they found other ways of communicating with patients.
- We found the rapid discharge and avoidance team used the Montreal Cognitive Assessment (MoCA) to assess people's needs prior to leaving the hospital. MoCA is designed to provide a screening facility to assess a patient's cognitive dysfunction.
- Staff told us that they were able to order specialist equipment such as pressure relieving or bariatric equipment and that it arrived in a timely way.

- The ward had a system where possible all activities on the ward stopped, if it was safe for them to do so. This should make staff available to provide assistance to those patients who needed support with eating and drinking. However at the time of the inspection there was no opportunity for this level of support to be provided to patients. Therefore the system was not responsive to people's nutrition or hydration needs.
- During our inspection we saw that staff often did not respond in a timely manner to patients that requested help or required assistance. For example, we saw that call bells were not answered for some time and we witnessed an elderly patient within a side room calling for help and we had to ask a nurse to intervene and assist the patient.
- We found that there was good links with the rapid discharge and action team. The team worked alongside patients to ensure they had the correct therapy plans in place on discharge. The health care professional said they worked closely with community staff and other based community services such as residential care homes to ensure care such as physiotherapy intervention was provided.
- Staff told us they little awareness of dementia or people with learning disabilities. When asked they could not provide the names or identify who they would speak with regarding learning disability or dementia. No champions were for these conditions were in place.
- Staff knew who to contact and where to access the specialist support team for people with mental health problems.
- There were many leaflets available for people in the EAU, the leaflets were stocked and covered a range of conditions including COPD, Dementia and Deep Vein Thrombosis to provide information to patients and relatives.
- There was a discharge lounge with 6 seats and a small sofa. This was in a bay where two spare beds were stored on the day of our inspection. The bay was situated halfway down the corridor, which meant that relatives would have had to walk past bays and side rooms to reach it. The seats were arranged in two rows, in a corner. There was no TV, radio, magazines or focal point. The seats looked out into the corridor, so there was no privacy or peace from the noise of the EAU. There appeared to be no supervision of the patients in the discharge lounge. We saw seven patients waiting there during the afternoon.

Learning from complaints and concerns

- The complaints process was outlined in information leaflets, which were available on the ward areas.
- Six members of staff told us that they were not always made aware of complaints and did not receive feedback about complaints or learning from these.
- We viewed two governance and staff meeting minutes made available to us and found that complaints were not discussed with staff at local meetings or at governance meetings. Staff informed us that other meetings had taken place but the minutes of those minutes had not been written up or shared.
- We reviewed the complaints data for the emergency medicine service over the past six months. Trends of complaints had been identified however no improvement plans or action points had been created as a result of the findings. The top three reported complaints for the service were staff attitude, diagnosis and treatment plans.

Are medical care services well-led?

Requires improvement

Leadership of the EAU required improvement. Staff were unaware of the vision for the hospital as a whole and were also unclear if there was a dedicated vision or strategy for the unit. The department was led by the clinical director for medicine, a matron and a general manager. The team also covered the emergency department but regularly closed to admissions despite the impact this had on the emergency department. We found the nursing, matron and consultant leadership within the Emergency Assessment Unit local had the capability and skills to provide a good service however they were not empowered to provide good or effective leadership due to pressures of the demand on acute medical services. This meant that they could not provide the care they wanted to provide as they were not supported by senior management to deliver good care.

Governance meetings were held sporadically but minutes of those meetings were not always recorded. This meant that information from those meetings could not be shared with those who were unable to attend and no action points

could be taken forward to future meetings. Of the minutes viewed there were no action points, particularly learning from incidents and complaints. Therefore governance processes on the unit were not robust.

Staff told us that they were not always consulted or involved in the decision to open extra beds. Staff appeared under constant pressure and there were insufficient resources to implement change. Senior staff did not have the capacity to lead effectively because they were required to care for patients due to staff shortages. This meant that risks, issues and poor performance could not be dealt with in a timely way.

Staff satisfaction was mixed. Staff locally spoke highly of local managers though they felt that senior management within the trust was not visible or effective. Staff saw the interim chief executive as a visible person who was trying to make a difference. Due to shift arrangements, there was a lack of senior clinical nursing leadership out of hours. There was respect for colleagues across all disciplines but staff told us that they were not always supported which they attributed to the busyness of the unit.

The culture appeared open though staff were hesitant to raise any concerns regarding problems with the service said that they felt that the culture was improving. The majority of staff we spoke with during the inspection when asked if they would raise a concern said they did not feel like they would be listened to.

Vision and strategy for this service

- We spoke with both junior and senior medical staff during the inspection. The majority we spoke with were not aware of the Trust's vision and strategy. Staff expressed concerns about the changes to the executive board and were concerned about potential instability of senior staff in interim posts.
- A formal staffing review had been recently undertaken, the results of which were due to be reported. Staff were optimistic that the recommendations would be implemented but were unsure as to what staffing numbers had been recommended. Amongst the recommendations suggested was to divide the EAU into two different units, to make it more manageable. Building work to physically facilitate this was already underway.

Governance, risk management and quality measurement

- Wards used a quality dashboard and safety thermometer to measure their performance against key indicators though this was not displayed.
- There were monthly governance meetings attended by the MDT. We saw the meeting minutes dated 01 October 2014. They stated that minutes to the previous meeting were not available. When asked the trust confirmed that these minutes were not recorded and could not be provided.
- The headings of items discussed at the governance meetings included, quality and safety, falls, complaints and risks/incidents, the recording of discussions was non-specific, for example incidents did not appear to be discussed in detail. There were no action points, particularly learning from incidents and complaints. Therefore governance processes on the unit were not robust.
- Most junior staff we spoke with were unsure of how governance worked to improve patients' care and did not see the relevance of the meetings as no improvements had taken place. There was no evidence found during the inspection to support any improvements made or who was accountable for change and development from either the medical or nursing teams.

Leadership of service

- Staff expressed concern about the changes to the senior leaders at divisional level following the recent departure of the director of nursing. These staff members had not been in post long enough to make an impact or make positive changes to the staff's daily working.
- The unit was led by a matron, and a consultant clinical lead. The charge nurse was usually not supernumerary, so they had a number of patients allocated to them to care for. This meant that, apart from the patient care coordinators who did not have operational responsibility, there was no one on each shift with an overview of what was going on with regards to patient acuity, awareness of deteriorating patients, staffing levels and patient flow.
- We found during the inspection that the nurse leaders including charge nurse, matron and consultants on the EAU were trying to deliver a good service and trying to

demonstrate good leadership however they were not supported to do so by senior management and the pressures of providing an acute medical service with continual demand on inpatient capacity.
- There were no Band 7 (senior) nurses on duty during the night; however, the staffing review had recommended that both of these issues should be addressed to increase senior clinical leadership on the unit.
- All grades of staff reported that the high level of senior changes within a short period of time made it difficult to get to know everyone involved and to manage all the new changes. Therefore the team was not working
- Staff told us that senior board members were not visible within the trust. The only person visible for the staff on EAU was the interim chief executive who does team briefings with senior staff. All staff reported that the interim chief executive was approachable.

Culture within the service

- Staff shared their views about the service openly and constructively. They were caring and passionate about the hospital and about the care they provided to patients. Staff felt they worked well together as a team.
- Several staff members told us that they felt that doctors and nurses did not want to work in the EAU mainly due to the adverse publicity the hospital had attracted over the past year. One staff member said, "We've had such a bashing, we just want to get some decent, permanent staff and get on with making sure our patients get the best care."
- Staff worked well together and there was obvious respect not only between the specialities, but across disciplines.
- Nursing staff said that they did not always feel supported by their immediate line managers. One told us, "It's not their fault, everyone is too busy."
- There was a strong culture of teamwork and commitment from the permanent nursing staff in the EAU, focussed on supporting each other. The staff were determined to see change within the service and wanted improvements to take place. The staff had the best intentions to provide a good level of care however the operational delivery of the service at present means that this is not always possible.
- Senior staff we spoke with described a unit under constant pressure and that there was insufficient time or resources to plan changes for the unit at a local level. A number of staff told us they were always working at a significant pace and could not implement change, one staff member described their work as "firefighting" on each shift.
- Several junior and senior staff spoken with told us that they were not routinely involved or consulted in the decision making process to open further beds an reported to us that the decisions were taken operationally by senior management without consultation on the impact to patient care. This demonstrated a lack of communication between senior staff and unit management.
- Staff reported to us that they did not feel listened to when escalating risk around the safety of patients on the unit. Overall morale in the service was low.

Public and staff engagement

- There was information displayed throughout the public areas about The Patient Advice and Liaison Service (PALS.) However patients were not routinely provided with information about how to make a complaint.
- Although the EAU had posters publicising their values, only the Matron and Band 7 nurses were involved in devising these. There was no junior staff or patient involvement in their creation or design.
- Information was made available to patients and members of the public through the public website, with regular updates on the service posted. People were also directed through the internet page to the trust's social media services to receive updates.
- The trust used social media services to respond to any concerns or positive comments shared about the service to capture as many events as possible.
- Staff meetings were scheduled however due to how busy the unit was these did not always take place and where meetings did occur on two occasions in the last six months meeting minutes were not written up. Therefore information from those meetings could not be shared with those unable to attend.

Innovation, improvement and sustainability

- Staff within the EAU spoke positively about the service they provided for patients, but were frustrated by staff shortages.
- The senior staff were satisfied that a formal staffing review had taken place and were hopeful that recommendations would be approved. However there was some uncertainty at how quickly staff could be recruited.

Medical care (including older people's care)

- Nursing and therapists described the recruitment process taking too long. Although they understood that recruiting someone into a post took time, they described that more staff seemed to be leaving than being recruited into posts. There was Trust wide recruitment going on overseas.
- The level and pace of work on EAU was not sustainable. The number of beds open at the time of the inspection, staff stress and frustration levels as well as the increased clinical dependency and demand of patients meant that the service being delivered was not safe, effective, responsive or well led and it also resulted in staff not providing a caring service.
- Since the inspection we have been informed by the trust that they have taken immediate action to improve the safety and wellbeing of patients and staff on the ward by reducing the EAU bed base to 30. The executive team were working to maintain a lower bed base to ensure a good quality of care is provided. However since our inspection we were informed that these beds had been reopened due to a surge in admissions from the emergency department. Therefore were not assured that safety measures remained in place and opted to return to review the concerns raised.
- During our inspection on 23 December 2014 we found that the service reduced the bed base down to 41 from 62 following our previous visit. However due to pressures the bed base had been increased to 55 again and GP triage was closed on all days except for one day in the previous ten days. All patients requiring GP triage were referred through the A&E department.
- The trust was not meeting the standard required to comply with regulations. We have judged that there has been a major impact on patients who use the service. This is being followed up and we will report on any action when it is complete.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Importantly, the hospital must:

- Ensure that a patient's mental capacity is assessed appropriately and that records are up dated and maintained in accordance with the Mental Capacity Act 2005.
- Ensure that care provided in the best interest of the patient complies with the legal framework of the Mental Capacity Act Deprivation of Liberty Safeguards so that if a patient is restrained this is undertaken appropriately.
- Ensure that treatment in the emergency department particularly around head injuries and chest pain, is provided in accordance with NICE guidelines.
- Ensure that there is a standard operating procedure (SOP) in place for patients who are clinically assessed as safe to be 'stepped down' from the resuscitation department to the EAU.
- Ensure that the early warning score system (NEWS) is used effectively to respond to the risks of patient deterioration in a timely way.
- Ensure that there is a robust incident and accident reporting system in place to ensure that lessons learnt from investigations are shared with staff to improve patient safety and experience.
- Ensure that staff complete their mandatory training and have access to necessary training, especially safeguarding vulnerable adults and children, mental capacity and resuscitation, and development to ensure they maintain the appropriate skills for their role.
- Ensure that all patients' records are kept up to date and appropriately maintained to ensure that patients receive appropriate and timely treatment.
- Ensure that there are sufficient numbers of qualified, skilled and experienced staff at all times, particularly in the Emergency department and on the EAU.
- Review the patient flow from the A&E department to ensure that patients are assessed to meet their needs and there are no unnecessary delays.
- Review the complaints process to ensure that appropriate lessons can be learned and improvements made in service delivery.
- Ensure all staff adhere to the infection prevention and control of infection policy and procedures, particularly with regard to hand washing, cleaning procedures and curtain changes in the Emergency department and on the EAU.
- Ensure that do not attempt cardio-pulmonary resuscitation complies with best practice and national guidance, involves the patients or their representatives and that these discussions are recorded, those decisions are communicated with all staff to ensure that those decisions are respected.
- Ensure that the plans for escalation of high patient activity in the emergency department are reviewed to ensure that the service responds to surges of activity in a timely way.
- We would normally take enforcement action in these instances, however, as the trust is already in special measures we have informed Monitor of these breaches, who will make sure they are appropriately addressed and that progress is monitored through the special measures action plan.

Action the hospital SHOULD take to improve

In addition, the hospital should:

- Review the involvement of staff within the emergency department and EAU to ensure that staff are fully aware and engaged with the trust vision, strategies and objectives and can contribute to the development of services.
- Ensure that the bed base within the EAU is maintained at 45 inpatient beds and 17 GP triage beds where reasonably practicable.
- Provide additional support to managers and staff within the emergency department and EAU at times of high service activity.
- Review the information following clinical audits and ensure that any actions and learning are shared with staff.
- Review the training available to staff on caring for people living with dementia or with a learning disability and provide training to ensure that staff have the appropriate skills for their role.

Outstanding practice and areas for improvement

- Review the procedures within the emergency department of transferring or transporting deceased patients during periods of high activity to ensure the dignity of the deceased is respected.