Aintree University Hospital NHS Foundation Trust

University Hospital Aintree

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Aintree University Hospital NHS Foundation Trust (the trust) is a large teaching hospital in Liverpool.

There are 706 inpatient beds, serving a population of around 330,000 in North Liverpool, South Sefton and Kirkby. The hospital provides care and treatment for people living in some of the most deprived areas in England.

The hospital provides a full range of acute services which include: acute medicine, accident and emergency, acute frailty unit, surgical services. In addition to these services, the trust provides specialist services for Merseyside, Cheshire, South Lancashire, and North Wales. These specialist services include: major trauma, complex obesity, head and neck surgery, upper gastrointestinal cancer, hepatobiliary, endocrine services, respiratory medicine, rheumatology, ophthalmology, and alcohol services.

The hospital is one of the largest employers locally with more than 4,000 whole time equivalent staff. The trust gained foundation trust status in 2006 and was one of the first hospitals in Merseyside to do so.

Urgent and emergency services at Aintree University Hospital were previously inspected in March 2014 and were rated as 'good'.We carried out an unannounced responsive inspection of urgent and emergency services to review pathways of care when patients attended the service were receiving treatment from the service, and when they were transferred out of the service at Aintree University Hospital. The inspection was in response to concerns that were raised with us about the safety and quality of the service provided to patients. This inspection focused predominantly on the safety of the urgent and emergency services provided; however, where inspectors observed practice in other areas we have included this information in our report.

We inspected the hospital during the afternoon and evening of 1 April 2016. We visited the following areas:

- Accident and emergency (A&E);
- Observation Unit ;
- Acute medical unit;
- Wards 30 and 31 (which included the frailty unit);
- The bereavement centre to review records.

We found that urgent and emergency care services required improvement for safety. This was because the systems and processes for recognising and escalating the deteriorating patient were not always adhered to, to keep people safe.

We reported our findings to senior staff at the trust at the time of the inspection and actions were put in place to address the concerns.

Our key findings were as follows:

- Nurse staffing levels were not always filled to the safe staffing establishment, and staffing was below the safer staffing establishment on the SAU, ward 31 and in the accident and emergency department at the time of our inspection. There were periods of understaffing against the establishment over a number of days prior and post inspection and we saw evidence that staff had raised staffing concerns using the incident reporting process. The trust was taking action to address the nurse vacancy rate, but it remained evident that the wards were not always staffed to establishment.

Summary of findings

- Staff were using a national Modified Early Warning Score (MEWS) tool to help monitor a patient's condition and identify signs of deterioration in their condition. However, we found examples where these were not completed in line with the trust's MEWS Standard Operating Procedure. This included: MEWS not correctly calculated and repeated observations not being performed in line with the timeframes identified in the trust's MEWS Standard Operating Procedure. We were concerned that this may not appropriately identify patients who were deteriorating.
- We found there was poor staff compliance with the trust's mandatory training target. The trust had a plan in place to reach 85% compliance by March 2017. However, patients could be at risk if staff were not adequately trained in a timely manner.
- There was generally good practice with regard to infection control.

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

Importantly, the trust must:

- Ensure staff undertake and record patient observations consistently and accurately.
- Ensure that staff adhere to the modified early warning score (MEWS) Standard Operating Procedure and the sepsis clinical guidance document that the trust has in place to minimise risk of harm to patients.
- Ensure that staff perform out repeat observations in line with the clinically indicated MEWS trigger.
- Ensure that staff are trained and competent to identify and escalate the deteriorating patient.
- Improve staff compliance with mandatory training in a timely way.
- Ensure that staffing levels in all areas adhere to the safer staffing requirements.
- Ensure that patient records are completed contemporaneously and reflect the care provided to patients.

In addition, the trust should:

- Put in place robust audit processes to identify any areas where performance or practice requires improvement.
- Consider how lessons from incidents are shared and audited to identify if learning has been applied and is embedded throughout the trust.
- Have robust procedures to replace equipment on resuscitation trolleys in a timely manner across the trust to reduce the potential risk to patients who experience a cardiac or respiratory arrest.
- Review areas used for escalation purposes to ensure they are suitable for the service provided, based on patient need.
- Consider options to improve the privacy and dignity for patients during times when the trust is utilising the escalation policy due to periods of increased demand on the services.

Professor Sir Mike Richards
Chief Inspector of Hospitals

University Hospital Aintree

Detailed findings

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Detailed findings

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Background to University Hospital Aintree

Aintree University Hospital is a large teaching hospital in Liverpool, which is part of Aintree University Hospitals NHS Foundation Trust (the trust). There are 706 inpatient beds, serving a population of around 330,000 in North Liverpool, South Sefton and Kirkby. The hospital provides care and treatment for people living in some of the most deprived areas in England.

The hospital provides a full range of acute services which include: acute medicine, accident and emergency, acute frailty unit, surgical services. In addition to these services, the trust provides specialist services for Merseyside, Cheshire, South Lancashire, and North Wales. These specialist services include: major trauma, complex obesity, head and neck surgery, upper gastrointestinal cancer, hepatobiliary, endocrine services, respiratory medicine, rheumatology, ophthalmology, and alcohol services.

The hospital is one of the largest employers locally with more than 4,000 whole time equivalent staff. The trust gained foundation trust status in 2006 (one of the first hospitals in Merseyside).

Our inspection team

Our inspection team was led by:

Inspection Manager: Simon Regan, Care Quality Commission

The team included two CQC inspectors and a specialist advisor who was a doctor specialising in acute medicine.

How we carried out this inspection

We carried out an unannounced responsive inspection of urgent and emergency care services on the 1 April 2016 following concerns raised about the implementation of the escalation policy, unsafe staffing levels, adult safeguarding, and recognition and escalation of the deteriorating patient. At the time of our inspection we reviewed pathways of care when patients attended the service, were receiving treatment from the service, and when they were transferred out of the service at Aintree University Hospital.

We visited a number of areas which included: Accident and Emergency Department , Observation Unit, Acute Medical Unit, surgical admissions unit, wards 30 and 31 which included the frailty unit, and the bereavement centre to review records.

During our inspection we spoke with 21 staff, which included: nurses, matrons, ward managers, consultants, doctors, agency staff, healthcare assistants, and a clinical director. We spoke with four patients and their relatives.

Detailed findings

We reviewed 15 sets of patients' records, 28 patient admission cards, and 20 modified early warning score charts.

Urgent and emergency services

Safe	Requires improvement
Overall	Good

Information about the service

Aintree University Hospital NHS Foundation Trust (the trust) is a large teaching hospital in Liverpool.

There are 706 inpatient beds, serving a population of around 330,000 in North Liverpool, South Sefton and Kirkby. The hospital provides care and treatment for people living in some of the most deprived areas in England.

The hospital provides a full range of acute services which include: acute medicine, accident and emergency, acute frailty unit, surgical services. In addition to these services, the trust provides specialist services for Merseyside, Cheshire, South Lancashire, and North Wales. These specialist services include: major trauma, complex obesity, head and neck surgery, upper gastrointestinal cancer, hepatobiliary, endocrine services, respiratory medicine, rheumatology, ophthalmology, and alcohol services.

The hospital is one of the largest employers locally with more than 4,000 whole time equivalent staff. The trust gained foundation trust status in 2006 (one of the first hospitals in Merseyside).

We conducted an unannounced inspection on 1 April 2016 between 12pm and 8.30pm. We reviewed pathways of care when patients attended the urgent and emergency care service, which included receiving treatment from the service, and when they were transferred out of the service at Aintree University Hospital. We observed how care and treatment was provided. We talked to staff and senior management, visited ward areas and reviewed patient care records. We reviewed information that the trust provided to us after the inspection.

The areas we visited included: Accident and Emergency Department , Observation Unit ,Acute Medical Unit, surgical admissions unit, and wards 30 and 31 which housed the frailty unit.

As part of the inspection, we spoke with 21 staff which included: nurses, matrons, ward managers, consultants, doctors, agency staff, healthcare assistants, and a clinical director. We spoke with four patients and their relatives.

We reviewed 15 sets of patient's records, 28 patient admission cards, and 20 modified early warning score (MEWS) charts.

Urgent and emergency services

Summary of findings

We rated urgent and emergency services as 'requires improvement' for safe because;

- Evidence from the unannounced responsive inspection on 1 April 2016 and the findings provided by the trust, confirmed that there were some failings in recognising, documenting, and escalating the deteriorating patient.
- We were not assured that learning from incidents was taking place. There had been previous incidents of concerns in relation to recognising the deteriorating patient, lessons and actions had been identified via root cause analysis of the incidents; however, there had been repeated incidents.
- The trust had a clinical guidance document for the management of sepsis. We found during the period of April 2015 to February 2016, of the 548 patients deemed to meet the criteria for the pathway, there were missed interventions for 112.
- We found that the staffing levels, ward environment, and the number of medical outliers on the surgical assessment unit at the time of our inspection placed patients at risk of unsafe care and treatment.
- Compliance with both level two and level three basic life support mandatory training was low. The trust had a target of 85% compliance by March 2017; however, the timeframe of this target could place patients at risk due to inadequately trained staff.
- There was a delay in replacing some equipment on a resuscitation trolley on Ward 31.
- The trust's audit processes in place to monitor the recording of MEWS and staff knowledge in regards to recognising and escalating the deteriorating patient had identified 95.5% compliance and all staff in the audit were aware of the Standard Operating Procedure (SOP); however, this did not reflect the findings of our inspection and we were not assured that the audit systems in place were robust.

However;

- Patients on the frailty ward were having risk assessments, fluid balance charts, and comfort rounding completed in a timely manner.
- We observed good practice in relation to infection control during our inspection. Staff followed recognised hand hygiene practice, used hand washing facilities and wore personal protective equipment (PPE) when delivering care and treatment.
- The trust were achieving the target for tolerance of 46 cases of Clostridium difficile Infection (CDI) for the 2015/16 and there had been an improvement with a 15% reduction of cases since the previous year.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

Incidents

- There was an electronic system to report incidents and the staff we spoke to knew how to report incidents. Incidents were discussed at the trust's weekly meeting of harm and investigated. Prior to this inspection, we had seen investigations carried out using a root cause analysis (RCA) approach, with identified actions to implement to prevent recurrence.
- RCAs we reviewed from previous investigations had identified delays in escalating the deteriorating. For example, a RCA report following a death in August 2015 identified a failure to recognise the patients deteriorating condition was a contributory factor. Actions identified included the need for a clear escalation policy for the deteriorating patient in the emergency department. In addition, a RCA report following a patient death in September 2015 identified a failure to recognise the patients deteriorating condition was a contributory factor. Actions from the RCA included staff training and an internal safety alert to be sent to all wards.
- We reviewed recorded incidents prior to our inspection that occurred between January 2016 and March 2016 and found incidents of this nature continued. The incidents included: an unrecordable blood pressure identified at 3.50pm not escalated for approximately four and a half hours and was raised at the night shift handover and resulted in a call to the medical emergency team, a patient being identified with a MEWS score of four at 4pm not having observations recorded for the rest of the same day (at least six hours) when the trust policy advocates that a patient with a MEWS score of four should have repeated observations within 30 minutes, and a patient that had suffered with a seizure and required a call from the medical emergency team had no MEWS score repeated during the night shift (at least six hours). Due to the repeated incidents we were not assured that there was a robust system in place to disseminate lessons learnt from incidents.
- At the time of our inspection, a patient had a fall on ward 31 and an incident form was completed that same day.
- We saw evidence via the RCAs we reviewed that a process for the duty of candour was in place. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Cleanliness, infection control and hygiene

- Staff complied with the trust's policies and national guidance on the use of personal protective equipment. There was ample access to hand washing facilities, hand gel and personal protective equipment such as aprons and gloves. All staff followed bare 'below the elbow' guidelines when caring for patients and adhered to best practice guidelines in relation to hand hygiene.
- All areas we visited were generally clean and tidy; however, we visited ward 31 which had an unpleasant odour at the entrance to the ward. We discussed this with the ward manager who informed us that at times there had been several bins that were overfull left in the area. At the time of our inspection there was one large bin in the area and the ward manager informed us that they had reported the issue.
- We reviewed ten staff records on ward 31 and found all ten staff had completed mandatory infection control training.
- On ward 31 there had been a patient with unexplained diarrhoea identified and at the time of our inspection, the ward bay doors were closed as per policy and a sign indicating infection risk was observed on the doors to the bay.
- An escalation process was in place at the time of our inspection due to increased referrals to the trust and an outbreak of infection on the orthopaedic ward. Information provided to us by the trust identified appropriate actions had been taken to manage the outbreak of infection.
  - From February 2016 to March 2016 the trust reported two episodes of methicillin-resistant Staphylococcus aureus (MRSA) however; one episode was not apportioned to the trust.
- The trust had a tolerance of 46 cases of Clostridium difficile Infection (CDI) for the 2015/16 financial year which was set by NHS England. At the end of March 2016 the figure was 54 patients with CDI. However, 19 cases were successfully appealed by the Clinical Commissioning Group (CCG) CDI Appeals Panel as there

were no lapses in the patients care. These cases were not included for performance monitoring and so the year end performance was 35 cases, achieving the tolerance of no more than 46 cases of CDI, which represents a 15% reduction from the previous year.

Environment and equipment

- We reviewed the checklist for the resuscitation trolley on Ward 31 (elderly medical ward) where a cardiac arrest had occurred the day prior to our inspection. The checklist had been completed daily for the previous week and on the day of our inspection the checklist identified that two items were not on the trolley. We were told by staff that the trolley was checked every morning and we observed the trolley at 5.20pm. We asked a staff member if these items were now on the trolley: one item was a mask and oxygen tubing which was present and the other item was an ambu bag (a respiration device with a non-rebreathing valve to provide positive pressure for manual ventilation which is needed when a patient lacks respiratory drive during resuscitation), which was not present. A nurse told us that a spare was not kept on the ward and due to the cardiac arrest the previous day; an order had been placed with pharmacy for a replacement. When we approached the ward manager about this they advised us that there was now an ambu bag on the trolley, which we found to be in place. Due to the delay in replacing this we were concerned that this could have placed a patient at risk should a cardiac arrest present during the time when the trolley was not fully equipped.
- We checked two resuscitation trolleys on the acute medical ward. The checklists indicated that they had been appropriately checked in the required timescales and emergency drugs were found to be in date.
- The layout of the ward on the surgical assessment unit made it difficult for staff to have good visibility of patients on the ward. At the time of our inspection there were ten medical outliers on the ward some with increased risk of falls and some patients living with a cognitive impairment, such as dementia.
- There were occasions during our inspection when the A&E department was full to capacity. As there was a lack of space, this meant there were occasions when patients were handed over from the ambulance crew to a nurse and were kept on the corridor on a trolley. Staff told us that they used the resuscitation room to take blood samples and record physiological observations but, if there was no room in the department, the patient was returned to the corridor. We spoke to a patient and their family on ward 31. The patient told us they felt well looked after and the family were satisfied with the care the patient was receiving on the ward. The patient had initially been admitted via A&E and was on the A&E corridor. The family told us that whilst on the corridor nurses were available and they were communicated with. However, we saw one patient vomiting and there were no facilities to maintain their privacy and dignity.
- Escalation was part of the major incident procedures for the trust. A written escalation process was in place that outlined procedures for dealing with increasing levels of pressure on bed capacity within the trust. During times of increased capacity in A&E, the Observation Unit was changed into an overflow area for A&E.

Records

- We reviewed the nursing charts for one patient on ward 30 (frailty unit) who was identified as a risk of falls, needing fluids monitoring, and needing support with eating and had been admitted via A&E. We found the comfort chart had been completed at regular intervals with six entries at the time of our inspection, the food chart and fluid balance chart was completed to date. Pain assessment was recorded and the catheter chart was completed.
- We reviewed the medical records for two patients on ward 30 who had been admitted via A&E. We found all risks had been completed and the patients had received a medical review daily.
- We reviewed the case records for a patient on ward 31 at approximately 5.30pm that had fallen on the ward on the day of our inspection. The fall was recorded in the patient record by a doctor following a review of the patient. No additional observations were requested. We reviewed the nursing documentation which was also held within the patients case records and found there had been no entry in the record since the previous night shift. We asked the nurse caring for the patient why there had been no entry and were told it was too early to write the records up but that they had put a falls alarm on the patient. We asked again why the record had not been written to capture the change and were told it was due to having too many patients to look after.

This was the same patient that had developed unexplained diarrhoea. However, this was also not documented in the nursing record. Documentation did not reflect the care in place for this particular patient.

Safeguarding

- Staff displayed knowledge of the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DOLs).
- The trust provided staff with level one and level two safeguarding mandatory training. We reviewed the training records of ten staff on ward 31 and found that five out of ten staff were compliant with both level one and level two safeguarding.
- All ten staff were compliant with deprivation of liberties (DOLs) and mental capacity act mandatory training. Two ward managers told us that they were able to complete emergency DOLs requests which were emailed to the safeguarding team who then emailed the local authority who then should respond within 24 to 48 hours to complete the assessment. The ward managers raised concerns to us that patients were discharged and the assessments were not completed by the local authority and they felt that communication with the local authority safeguarding team was poor.
- Information provided by the trust prior to our inspection identified the process to alert staff and the safeguarding team if a patient was admitted with a learning disability passport. The trust had advised us that since December 2015 they were providing additional training to support staff dealing with patients with learning difficulties. We asked three senior members of nursing staff if they were aware of this process and none of them were. All three had not received training specifically in relation to learning disabilities and were not aware of the additional training.
- We reviewed the records of a patient that had been identified on the office board on ward 31 as having a DOLs in place. The patient was admitted via A&E where they were for a period of five hours. It had been recorded in the records that the patient had a DOLs in place in the community and would need the hospital to do an application. There was no record of this being actioned and no copy of the document in the patient records. We were not assured that this action had taken place.
- The trust had a system in place to identify patients with a diagnosis of dementia. A forget me not sticker was placed on the patient file. However, staff told us that this was not always initiated if the patient was admitted via A&E.

Mandatory training

- The Mandatory Risk Management Training (MRMT) was undergoing a full review and the way in which compliance was reported had recently been changed. A 'block' approach was being introduced to enable staff to complete all their required modules in one event or via e-learning within the same month. It was planned that staff would attend a MRMT refresher day and complete all their modules at once rather than having to attend a series of separate sessions throughout the year.
- The trust stated that the new approach will allow data reporting to be more transparent and report as either compliant or non-compliant for each individual staff member based on whether they have completed all required modules, rather than per module which it was felt did not provide the true picture of individual risk.
- The minutes from the Quality and Safety Meeting held on 21 March 2016 had identified a trust wide compliance with mandatory training as 46.5% against a target of 85% at quarter four of 2015/2016. The trust had a trust wide recovery plan to improve compliance with mandatory training which included a trajectory compliance target of 60% by the end of June 2016, 80% by the end of September 2016, and 85% compliance by the end of March 2017.
- Mandatory training compliance as at March 2016 in the accident and emergency department showed that 54.8% of staff were compliant with basic life support training level two, and 46.2% were compliant with basic life support level three. In the medical assessment unit 37.8% of staff were compliant with basic life support level two, and 67.0% compliant with basic life support level three. In the surgical assessment unit, 46.2% of staff were compliant with basic life support level one, and level two. The frailty unit were 75% compliant with level one, and 69.2% compliant with level three
- A&E had a dedicated Nurse Educator for the department who also undertook approximately two clinical shifts per month as an emergency nurse practitioner (ENP). Their primary role was education and training for the department including organising mandatory, essential,

and bespoke training. We were told that training was often cancelled due to low staffing levels. The trust was offering staff overtime payments to attend training which we were told was working well.

Assessing and responding to patient risk

- The service used different tools to triage patients and assess their clinical condition. These included the Manchester Triage System (MTS), a Modified Early Warning Score (MEWS) system and a sepsis indicator warning system.
- The MTS tool aims to reduce risk through triage, ensuring patients are seen in order of clinical priority and not in order of attendance. We saw evidence of MTS being used to triage patients.
- The MEWS system used clinical observations within set parameters to determine how unwell a patient may be. When a patient's clinical observations fell outside certain parameters they produced a higher score, which meant they required more urgent clinical care than others. A MEWS score was required as part of the patient's initial assessment, and at intervals for routine monitoring. The trust had a MEWS Standard Operating Procedure (SOP) which set out the actions and frequency of physiological observations and actions to be taken based on the clinically indicated MEWS. The trust SOP also stated that a MEWS was to be completed within 30 minutes of a patient arriving to a ward or department.
- We reviewed nine A&E admission (CAS) cards for patients that were on the acute medical unit at the time of our inspection who were originally admitted through A&E, and found that all nine did not have a MEWS recorded when they were first triaged in A&E. The nine patients had all presented at A&E with observations that were outside of normal ranges and included: increased heart rate, increased respiratory rates, low oxygen saturations, low blood pressure and pyrexia (raised temperature).
- We reviewed an additional 19 CAS cards for patients seen and discharged from the emergency department from 31 March 2016 to 1 April 2016 to determine if they had a MEWS and their observations recorded at the initial triage stage when they presented to the unit. One of the 19 patients did not have their observations recorded, and six did not have a MEWS recorded.
- We reviewed the observation charts (which included the MEWS) for 14 patients on the acute medical unit who were admitted via A&E or referred direct by the patients General Practitioner (GP). Of the 14 charts, ten had the MEWS completed and observation recordings in the timeframes identified in the trust policy. We found three charts where the MEWS SOP was not followed, and an additional chart where a patient had oxygen saturations of 81% (which was low and may indicate a respiratory risk for the patient) and the oxygen saturations were not repeated for a period of nine and a half hours. Of the three patients where the MEWS SOP was not adhered to; two patients had a MEWS score of three, which indicated observations were to be recorded at two hourly intervals but one was not repeated for nine hours and the other for eight hours. We found another patient with a recorded MEWS score of five which indicated a referral to the medical emergency team; however, observations were not repeated until five hours later. The lack of repeated observations in all these cases took place during night shifts.
- We reviewed the observation chart for a patient on ward 30 at the time of our inspection and found the MEWS was recorded as zero and observations had been recorded once at the time of our inspection and twice the previous day which adhered to the trust SOP.
  - At the time of our inspection, we alerted the Director of Nursing to these issues. The trust was provided with five case details to perform concise investigations of the patient journeys on these records where we had identified concerns during our inspection. The findings from the trusts review confirmed staff had failed to follow the trust's SOP. The issues identified included a failure to record and escalate raised MEWS, a lack of medical documentation, failure to calculate MEWS at the initial observations, failure to take action on patients changing condition, and observations not recorded within the trusts timeframe based on MEWS.
  - Following the concise investigations on the five patient records, the trust identified failings of staff knowledge in relation to MEWS, and no competency / training records in relation to MEWS on the Accident and Emergency department. The report did identify that no harm came to any of the five patients reviewed. This did not reflect the trusts previous findings when using the Aintree Assessment & Accreditation (AAA) System to audit A&E in March 2016.

The assessor questioned 50% of the staff on duty at the time of the assessment and found that all staff understood and knew the process for the nurse-led response to acutely ill patients.

- Minutes from the trust's Medical Emergency Team Operational Group which included meetings up to the 15 March 2016 had identified 95.5% compliance in relation to recording MEWS for quarter four of 2015/ 2016; however, the audit sample size was based on five records per ward/department. Due to the numbers of patients attending A&E compared to other wards, such a small sample for the department would make it difficult to determine any trends where there would be a higher proportion of acutely ill patients at risk of deteriorating. Previous incidents where the trust had performed RCA reports, had identified a failure to recognise the patients deteriorating condition as a contributory factor to two patients deaths. Actions from the RCAs included the need for a clear escalation policy for the deteriorating patient in the A&E department. As the findings from the MEWS audit performed up to March 2016 did not reflect our findings on inspection and the trusts findings following the five concise investigations, we were not assured that the audit sample size within A&E was adequate.

- Senior staff in the emergency department told us at the time of our inspection that patient flow was an issue and that MEWS and observations being done on time was an issue that was picked up by the matron. However, it was evident that it had not been addressed adequately at the time of the inspection.
  - The trust had a sepsis clinical guidance document in place to manage the patients with potential sepsis. Sepsis is a life- threatening illness caused by the body's response to infection. We reviewed the trusts sepsis performance data for the period April 2015 to February 2016 for patients admitted via the emergency department and both the medical and surgical assessment unit. There were 833 patients with a code relating to sepsis; following review by the trust, 548 patients were deemed to meet the inclusion criteria.
- Of these 548 patients, 112 were identified as having missed interventions and were classed by the trust as 'missed opportunities'. This means that there were 112 patients that did not receive all the interventions to treat sepsis within the timeframes identified in the trust's clinical guidance document.
- Of the 112 that were classed as having missed interventions, 23 died, one patient self-discharged, 87 were discharged on clinical advice, and one had an uncompleted hospital provider spell (which meant at the time of the audit they were still receiving treatment as an inpatient and their outcome at the time of the audit was unknown). Of the 112 patients, 89 were admitted via A&E. The trust highlighted that 93.4% of the 112 patients had an early warning score completed within 60 minutes of arrival in line with the clinical guidance document. However, only 80.3% had antibiotic medication administered within three hours of arrival. Administration of antibiotic therapy is a key factor in the treatment of sepsis, 77.9% had serum lactate taken within three hours of arrival, and 58.2% had a senior review or assessment by the critical care staff within four hours of arrival. This identifies that the trust were not always adhering to the trust's sepsis clinical guidance document.
- There were 436 patients from the initial sample that had received all the interventions as outlined in the trust's pathway for managing potential sepsis. Of these 436 patients, 109 had died.
- There was a trauma team available 8am to 8pm daily and the staff on this team had attended the trauma training offered by the trust and were all advanced life support trained. Outside of these hours the band 6 nursing staff in A&E took on the role of the trauma team coordinator. However, not all of the band 6 staff in A&E had undertaken the required trauma training at the time of the inspection.
- During times of high demand on A&E services, the A&E corridor was used to triage and monitor patients. We observed patients that were brought to A&E by the ambulance service being handed over to nursing staff on the A&E corridor. When hospital staff were unavailable, the ambulance staff stayed with the patient. Staff told us that patients on the corridor were never left unattended. However, at 5.43pm at the time of our inspection, we observed a patient on the corridor with no staff visible.

- We found a patient that was in a secluded side room that was not visible to staff on SAU did not have easy access to a call bell, despite being identified as a falls risk.
- One patient and their family told us that during the night they waited up to 20 minutes on SAU for staff to respond to the call bell.

Nursing staffing

- At the time of our inspection we found that the establishment for safe staffing in A&E was 18 registered nurses (RNs) on days however, there were 16 RNs on duty. We reviewed the off duty for nurse staffing in A&E for four days from the 21 March 2016 to the 28 March 2016 and found there were nursing staff shortages on each day shift.
- At the time of our inspection the acute medical unit (AMU) had the planned number of both nursing and medical staffing on duty.
- The surgical assessment unit had a staffing establishment that was based on 20 beds. There was a General Practitioner assessment area on the unit where patients were assessed. During times of increased pressure, the assessment unit was used as part of the trusts escalation policy and additional beds were placed in the area. We found that staffing was not increased when the flexible beds were in use.
- We found that the actual nurse staffing levels on the surgical assessment unit were less than the establishment for safe staffing at the time of the inspection. The agreed safe staffing levels identified for a long day was five registered nurses (RNs) and three healthcare assistants (HCAs), and for a night shift, four RNs and two HCAs. There were three RN on duty at the time of our inspection and one of those included the ward manager. The ward manager was often included within the numbers of staffing which could have a negative impact on their ability to provide the ward with clinical leadership. We reviewed the rota for the 28 March 2016 and found one RN and one HCA short on both the day and night shift. On the 29 March 2016 we found one RN short on day shift and on the 30 March 2016, two RN short on the day shift.
- We reviewed the staffing rota for a period of seven days from the 1 April 2016 to 7 April 2016 for the surgical assessment unit. We found, out of 35 RNs day shifts, 10 were not filled to establishment and of the 25 shifts filled, three were filled with bank or agency staff. Out of the 28 RN night shifts, nine were not filled to the establishment and of the 19 filled; five were filled by bank or agency staff.
- We found for the seven day period the trust were not meeting the safe staffing levels for RNs for all day and night shifts. In five of the seven days the ward manager was counted within the establishment: however, the numbers were still below planned staffing on these occasions. On six days there was more than the establishment of 20 patients which ranged between 21 and 25 patients. The ward also took medical patients at times of bed pressures and on three days there were medical patients on the ward and staff had told us at the time of our inspection that taking medical patients was placing them under additional pressure.
- There was only one afternoon period during the seven days when the HCAs were below the establishment, the rest of the shifts had the required HCA staff to meet the safe staffing levels. There were more HCA shifts covered by the use of bank and agency staff. Out of the 21 day shifts available for HCAs, 15 were covered with bank or agency and of the 14 night shifts available ten were covered by bank or agency staff.
- On ward 31 the staffing establishment for days was six RNs and three HCAs. We reviewed the off duty for ward 31 for five days from 28 March 2016 and found the safe staffing levels for trained nurses on the ward were not in place for three of the five day shifts. We spoke with a clinical director who told us that they felt that ward 31 was unsafe due to the numbers of nursing staff.
  - At the time of our inspection, ward 31 had 7.8 whole time equivalent (WTE) nursing vacancies, 1 WTE nurse on maternity leave, 1 WTE manager on sick leave, 13 hours of band 2 staff on long term sick leave and 2 nurses had taken sick leave the last two days. All the vacancies had been advertised. There was a replacement ward manager who had been seconded to this area to cover the ward managers sick leave at the time of our inspection.
- We observed a handover between nursing and therapy staff on ward 31 which included a discussion of needs, risks, care packages and discharge arrangements for patients.
- We spoke to an agency nurse who had been block-booked by the trust for a period of 12 months. They told us they had received a trust induction, had

access to mandatory training and had also been trained to administer intra-venous medication. The nurse was aware of the incident reporting policy and had reported an incident on the day of our inspection for a patient who had fallen. The staff member was able to articulate the process for recording MEWS and the escalation process.

Medical staffing

- Medical staffing for the emergency department was adequate to ensure patients received timely and safe care. Staff were able to access medical advice and assistance when they needed to.
- The acute medical unit had access to two consultants and senior house officers during Monday to Friday and one consultant during weekends. There was a nominated physician of the day that the ward had access to.
- There were three consultants that worked on ward 31. There was evidence in the patient records we viewed of comprehensive medical reviews for patients. These reviews included evidence of clear plans of care and active management of patient's medical issues.
- At the time of our inspection we were told by staff on the SAU that there were delays in medical staff reviewing medical outliers (patient's that were on a ward that may not be best suited to their needs) on the ward. We saw incidents recorded in relation to delays in access to medical staff on the unit.

Escalation Management

- Escalation was part of the major incident procedures for the trust. A written escalation process was in place that outlined procedures for dealing with increasing levels of pressure on bed capacity within the trust.
- There is a Department of Health target for emergency departments to admit, transfer or discharge 95% of patients within four hours of arrival. We reviewed the data for the four days prior to our inspection and found there had been a total of 342 breaches with the range of compliance between 54.4% to 78.75
- The trust had introduced admissions to wards at 9am each morning. Staff informed us that this results in patients that are being discharged having to give up their beds and have had to sit at the nurse's station to eat their breakfast. This resulted in 38 patients on ward 31 until approximately 11am. Staff told us there was a discharge lounge but that it was inappropriate to send the patients there.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

The provider must ensure:

- Staff undertake and record patient observations consistently and accurately.
- Staff adhere to the modified early warning score (MEWS) and sepsis policies that the trust has in place to minimise risk of harm to patients.
- Staff perform repeat observations in line with the clinically indicated MEWS trigger.
- Staff are trained and competent to identify and escalate the deteriorating patient.
- Staff compliance with mandatory training is improved in a timely way.
- Staffing levels in all areas adhere to the safer staffing requirements.
- Patient records are completed contemporaneously and reflect the care provided to patients.

Action the hospital SHOULD take to improve

The provider should:

- Put in place robust audit processes to identify any areas where performance or practice requires improvement.
- Consider how lessons from incidents are shared and audited to identify if learning has been applied and is embedded throughout the trust.
- Have robust procedures to replace equipment on resuscitation trolleys in a timely manner across the trust to reduce the potential risk to patients who experience a cardiac or respiratory arrest.
- Review areas used for escalation purposes to ensure they are suitable for the service provided, based on patient need.
- Consider options to improve the privacy and dignity for patients during times when the trust is utilising the escalation policy due to periods of increased demand on the services.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The provider did not do all that was reasonably practicable to mitigate risks for the deteriorating patient. This is because; There were failings in recognising, documenting, and escalating the deteriorating patient and staff did not always follow the trust's policy. We were not assured that learning from incidents was taking place. There had been previous incidents of concerns in relation to recognising the deteriorating patient, lessons and actions had been identified via route cause analysis of the incidents: however, there had been repeated incidents. The trust had a policy and pathway for the management of sepsis. We found during the period of April 2015 to February 2016, of the 548 patients deemed to meet the criteria for the pathway, there were missed interventions for 112. HSCA 2008 (Regulated Activities) Regulations 2014 Regulation 12 (1) (2) (a) (b) (c)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** We found that there wasn't always the appropriate numbers of staff on duty. At the time of our inspection

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Requirement notices

there were nursing staff shortages on A&E and the actual nurse staffing levels on the surgical assessment unit were less than the establishment for safe staffing. There were also shortgaes on other dates.

There was poor compliance with mandatory training, with basic life support low in particular.

HSCA 2008 (Regulated Activities) Regulations 2014

Regulation 18 (1) (2) (a)