

Portsmouth Hospitals NHS Trust

Queen Alexandra Hospital

Quality Report

Queen Alexandra Hospital

Portsmouth

Hampshire

PO6 3LY

Tel:02392286000

Website: www.porthosp.nhs.uk/

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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

Urgent and emergency services

Requires improvement



Medical care (including older people's care)

Requires improvement



Summary of findings

Letter from the Chief Inspector of Hospitals

Queen Alexandra Hospital is the acute district general hospital of the Portsmouth Hospitals NHS Trust. It is the amalgamation of three previous district general hospitals, re-commissioned into a Private Finance Initiative (PFI) in 2009. The hospital currently has 1,053 inpatient beds, and has over 140,000 emergency attendances each year.

Prior to this inspection, we had undertaken an unannounced and focussed inspection at the Queen Alexandra Hospital on 22 and 23 February and 3 and 4 March 2016. We inspected the Emergency Department (ED) and Medicine, specifically the urgent medical pathway. At that time we found some patients in the emergency department (ED) were at risk of unsafe care and treatment and there were areas of poor practice where the trust needed to make improvements.

We considered that people who used the emergency services at Queen Alexandra Hospital would, or may be, exposed to the risk of harm if we did not impose urgent conditions for the Trust to provide a safe service to patients. On 15 March 2016, we took urgent action and issued a notice of decision to impose conditions on their registration as a service provider.

We told the trust to take immediate action, under section 31 of the Health and Social Care Act (2008), and imposed four conditions on their registration. We told the trust to immediately ensure;

- A clinical transformation lead had been appointed based on external advice and agreement, and ensure effective medical and nursing leadership in the emergency department.
- Patients attending the Emergency Department at Queen Alexandra Hospital were triaged, assessed and streamlined by appropriate staff, and escalation procedures are followed.
- The “Jumbulance” was not used on site at the Queen Alexandra Hospital, under any circumstances. The exception to this will be if a major incident is declared.
- CQC received regular monitoring information from the trust.

At that time, we rated urgent and emergency services as inadequate and medical care as requires improvement.

On 29 and 30 September 2016 we undertook an unannounced focussed inspection of the emergency care pathway at the Queen Alexandra Hospital. The focus of our unannounced inspection was on the actions the trust had taken as a result of the urgent conditions imposed on them to improve the identified risks to patients through their emergency care pathway. We inspected two core services urgent and emergency care and medical services.

We rated Queen Alexandra Hospital as ‘requires improvement’ for both urgent and emergency services and medical care.

Our key findings were as follows:

- Significant improvements had been made within the emergency department since our last inspection in February 2016,
- A senior medical transformation lead had been appointed and was working with the trust to make necessary changes.
- The vehicle known as the Jumbulance (a large multi patient use ambulance) vehicle had been removed
- The department had submitted performance monitoring data to CQC and had started to use this in its own improvement reporting.
- Incident reporting and figures about delays in treatment were now more accurately reflected emergency department activity.

Summary of findings

- There were effective clinical governance arrangements and reporting to the trust board.
- National clinical audits showed that patient outcomes were better than many other hospitals within the Emergency Department.
- Staff in the emergency department treated patients and their relatives with dignity, respect and compassion.
- There was a proactive frailty intervention team, which worked with emergency department staff to coordinate care.
- There had been improvements since our last inspection; however patients were still spending too long in the emergency department. There were occasions when patients had to wait outside in ambulances, although these were rare and for shorter periods of time than previously. During our last inspection we observed patients waiting for more than two hours before ED staff carried out a clinical assessment. Since then waiting times, monitored on a weekly basis, have seen a gradual improvement in recent months. Trust monitoring data demonstrated that no patients had waited for two hours or more for a clinical assessment since May 2016. By September 2016 90% of ambulance patients were assessed within 15 minutes.
- There had been increased staff engagement via lunchtime drop-in sessions and multi-disciplinary staff engagement meetings. This had helped to reduce the culture of “learned helplessness” that we had found during the previous inspection. Staff were able to be more pro-active in effecting positive changes in patient care.
- Ambulance patients were sometimes left in a corridor with no-one observing them and with no means of calling for help.
- There were delays, caused by a lack of empty beds on wards, which sometimes resulted in a crowded department.
- Emergency department staff expressed doubts regarding the sustainability of recent improvements. They felt that it was too early to say whether the latest changes would become embedded throughout the hospital.
- The culture of the consultant body and the hospital did not support effective change with the urgent medical pathway Strategies designed to improve the urgent medical pathway were not yet fully embedded and meeting their planned expectations.. Lack of medical staff allocated to escalation areas and the winter pressures ward, had a detrimental effect on patient flow through the hospital.
- Leadership on AMU was medically driven, with minimal input from the nursing team. Staff in some wards and clinical areas felt the senior management team was disengaged from them, their views were not listening to and they felt they were just left to “get on with things.” Staff felt demoralised by continued lack of improvements in the urgent care pathway. However, we did see there was good local leadership in some clinical areas.
- Governance processes throughout the medical pathway were not effective at identifying risks and improving safety and quality of services provided.
- Systems, processes and standard operating procedures were not always reliable, consistent or appropriate to keep people safe. In AMU, and on the medical wards, infection control procedures were not consistently followed. Medicines management in AMU and on the wards did not always follow the trust procedures and did not protect the wellbeing of patients. On AMU confidentiality of patient records was not always maintained and some patient records across all areas were difficult to read.
- Care and treatment was inconsistent within the AMU. Some patients did not receive care based on assessment of risk or plans were not developed to support identified risks. Patients and their representatives were not routinely involved in planning and decision making processes about their care and treatment. We witnessed some care practices that showed empathetic and compassionate care was not always provided to patients.

Summary of findings

- Most patients had assessments for pain throughout their hospital stay, but staff did not consistently monitor the effectiveness of pain relief. In AMU patients did not always receive the support they needed at meal times because assessments had failed to identify the support they needed.
- The trust was failing to meet its target for completion annual appraisals and mandatory training targets were not consistently met for staff working in the emergency clinical services centre and medicine clinical services centre.. When some escalation areas were open, staff felt they did not always have the necessary skills to care for some patients.
- We noted breaches of mixed sex accommodation on day units where medical outliers were. The trust had not considered these as mixed sex breaches.
- Patients were frequently moved which affected the timeliness of discharge. Some patients had multiple bed moves and were moved at night. Data showed there had been no improvements in the frequency of patient bed moves since the last inspection. However, systems were in place, which ensured medical outliers were tracked and reviewed on a daily basis.
- Patients did not have access to timely discharge from hospital. The number of patients experiencing a delayed discharge had increased since the last inspection. Consultants and senior managers did not demonstrate any drive or innovation to promote the access and flow of patients through the hospital. Strategies designed to improve the urgent medical pathway were not yet fully embedded and meeting their planned expectations. The lack of medical staff allocated to escalation areas and the winter pressures ward, was having a detrimental effect on patient flow through the hospital because patients experienced delays in medical assessments.

We considered that the trust had made significant improvements to reduce the risk of harm to patients in the emergency department. On 13 October 2016 we issued a notice of proposal to remove the conditions imposed on their registration as a service provider made on 15 March 2016.

However, there were also areas of poor practice where the trust needs to make improvements.

During our inspection of the medical service we identified failings to comply with some requirements of the Health and Social Care Act 2008 and its associated regulations. These were:

- Regulation 10(1) (2) (a) Dignity and respect, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During our inspection we saw and identified practices that did not ensure that patient's privacy and dignity was always protected.
- Regulation 12(1) (2) (a)(b)(e)(g)(h)(l) Safe care and treatment, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We observed and found that patients were not always prevented from receiving unsafe care and treatment or prevented from avoidable harm or risk of harm.
- Regulation 17 (2) (a)(c) Good Governance, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During our inspection of the AMU we observed and found that the trust did not have effective assessing or monitoring systems to improve the safety or quality of the services provided. Providers must continually evaluate and seek to improve their governance and auditing practice. In addition we observed and found patient records were not consistently legible, timed dated or had the designation of the member of staff.

We asked the trust to address the failings we identified during our inspection and issued them with a Requirement Notice letter issued under Regulation 17 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As part of the notice the trust were required to send us an action plan which detailed how the trust planned to address the failings and improve the standard of services provided to patients. We received the Action plan from the trust within 28 days as requested.

Importantly, the trust must ensure:

Summary of findings

- All incidents and near misses are reported using the trust's incident reporting processes, and all staff receive feedback from reported incidents.
- All staff follow the trust's infection prevention and control procedures.
- Staff follow the trust's medicines' management procedures.
- All equipment is maintained and is ready and safe to use.
- All emergency equipment is checked, following trust procedures, to ensure all equipment is present, in date and in working order.
- Patient details and information are not accessible to unauthorised personnel.
- All patients have an individualised care plan to enable staff to provide the appropriate care and treatment.
- There is adequate medical cover at all times, including cover in escalation areas and the winter pressures ward.
- Completion of patient documents follows national guidelines, including accurate completion of food and fluid charts.
- Patients receive the assistance they need at meal times to reduce risks of malnutrition.
- Appraisals and supervision meets the trust's targets.
- Staffing at weekends does not have a detrimental effect on patients flow through the hospital and discharge planning.
- Staff are aware of their responsibilities towards the Mental Capacity Act 2005.
- Planning and delivery of care is in accordance with the Mental Capacity Act 2005.
- Needs of patients living with dementia are met.
- Mixed sex accommodation breaches are identified and reported and take action to reduce their occurrence
- Patients and their representatives are involved in planning and making decisions about their care and treatment.

In addition the trust should ensure:

- Mortality and morbidity meetings include learning from reviews of care and treatment.
- Safety thermometer information is displayed in all clinical areas.
- Planned and actual staffing levels are displayed in all clinical areas.
- Serious incidents are investigated in a detailed and comprehensive manner.
- There is sufficient flow of patients through the emergency department so that patients do not have to wait outside in ambulances.
- Ligature risk assessments are undertaken in all rooms that may be used by people with mental health problems
- Length of stay on AMU meets the trust target of less than 24 hours.
- Length of stay on the short stay ward meets the trust target of less than 72 hours
- The urgent medical care pathway is fully established and embedded into the management of the hospital.
- There is an action plan for, and a demonstrable reduction in patients being moved overnight.

Summary of findings

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Requires improvement



Rating

Why have we given this rating?

Overall we rated urgent and emergency services as requires improvement. Significant improvements had been made since our last inspection in February 2016 when we had found the department to be inadequate.

There had been improvements since our last inspection however patients were still spending too long in the emergency department. There were delays caused by a lack of empty beds on wards which sometimes resulted in a crowded department. Evidence shows that patient safety is comprised in these circumstances.

Infection control guidelines were not consistently adhered to across the emergency department. For example there were areas within the resuscitation room that were not clean and had not been checked; this increased the risk of cross infection to staff and patients.

There were occasions when patients had to wait outside in ambulances, although these were rare and for shorter periods of time than previously. We observed long delays before treatment was commenced by on-call specialist teams.

Ambulance patients were sometimes left in a corridor with no-one observing them. Although there were no call bells, there were signs which explained to patients why they were waiting in the corridor and asking them to tell a member of staff if they needed anything.

Many improvements had been made regarding patient flow. The department treated and discharged 82% of patients within four hours.

However, this was less than the national standard of 95% and less than the England average of 90% in the same time period. There were delays of up to 48 hours for patients with mental health problems who needed to be admitted.

Emergency department staff expressed doubts regarding the sustainability of recent improvements. Many of the improvements made recently had, of

Summary of findings

necessity, been reliant on external help and advice. Emergency department staff had been supported to make independent decisions about service improvements but this was at an early stage. However, Significant improvements had been made since our last inspection in February 2016 when we had found the department to be inadequate. The vehicle known as the Jumbulance (a large multi patient use ambulance vehicle) had been removed. The department had submitted daily performance monitoring data to CQC and had started to use this in its own improvement reporting. A senior transformation lead had been appointed and was working with the trust to make necessary changes. National clinical audits show that patient outcomes were better than many other hospitals. Staff in the department treated patients and their relatives with dignity, respect and compassion. There was a proactive frailty intervention team which worked seamlessly with emergency department staff. There were robust clinical governance arrangements with effective reporting to the trust board. Incident reporting and figures about delays in treatment now more accurately reflected emergency department activity. There had been increased staff engagement via lunchtime drop-in sessions and multi-disciplinary staff engagement meetings. This had helped to reduce the culture of “learned helplessness” that we had found during the previous inspection. Staff were able to be more pro-active in effecting positive changes in patient care.

Medical care (including older people’s care)

Requires improvement



Overall we rated medicine as “requires improvement”. Medical services were rated as inadequate for well led and requires improvement for safe, effective, caring and responsive. This demonstrates a deterioration in the service since the previous inspections in February 2015 and February to March 2016. Strategies designed to improve the urgent medical pathway were not yet fully embedded and meeting their planned expectations. Culture of the consultant body and the hospital did not support

Summary of findings

effective change of the urgent medical pathway. Lack of medical staff allocated to escalation areas and the winter pressures ward, had a detrimental effect on patient flow through the hospital. Leadership on AMU was medically driven, with minimal input from the nursing team. Staff in some wards and clinical areas felt the senior management team was disengaged from them, their views were not listening to and they felt they were just left to “get on with things.” Staff felt demoralised by continued lack of improvements in the urgent care pathway. However, we did see there was good local leadership in some clinical areas. Governance processes were not effective at identifying risks and improving safety and quality of services provided. Systems, processes and standard operating procedures were not always reliable, consistent or appropriate to keep people safe. In AMU and on the medical wards, infection control procedures were not consistently followed. Medicines management in AMU and on the wards did not always follow the trust procedures and did not protect the wellbeing of patients. On AMU confidentiality of patient records was not always maintained and some patient records across all clinical areas were difficult to read. Care and treatment was inconsistent within the AMU. Some patients did not receive care based on assessment of risk or plans were not developed to support identified risks. Patients and their representatives were not routinely involved in planning and decision making processes about their care and treatment. Most patients had assessments for pain throughout their hospital stay, but staff did not consistently monitor the effectiveness of pain relief. In AMU patients did not always receive the support they needed at meal times because assessments had failed to identify the support they needed. The trust was failing to meet its target for staff completion of annual appraisals for staff working in AMU and with the urgent medical pathway. The trust almost met their target of 85% compliance with mandatory training for staff working in the AMU and

Summary of findings

with the urgent medical pathway.. When some escalation areas were open, staff felt they did not always have the necessary skills to care for some patients.

We noted breaches of mixed sex accommodation on day units where medical outliers were. The trust had not considered these as mixed sex breaches.

We witnessed care practices that showed empathetic and compassionate care was not always provided to patients.

Patients were frequently moved which affected the timeliness of discharge. Some patients had multiple bed moves and were moved at night. Data showed there had been no improvements in the frequency of patient bed moves since the last inspection.

However, systems were in place, which ensured medical outliers were tracked and reviewed on a daily basis.

Patients did not have access to timely discharge from hospital. The number of patients experiencing a delayed discharge had increased since the last inspection. Consultants and senior managers did not show drive and innovation to promote the access and flow of patients through the hospital.

Strategies designed to improve the urgent medical pathway were not yet fully embedded and meeting their planned expectations. Lack of medical staff and therapists allocated to escalation areas and the winter pressures ward, had a detrimental effect on patient flow through the hospital.

Queen Alexandra Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Medical care (including older people's care)

Detailed findings

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Background to Queen Alexandra Hospital

Queen Alexandra Hospital is the acute district general hospital of the Portsmouth Hospitals NHS Trust. It is the amalgamation of three previous district general hospitals, re-commissioned into a Private Finance Initiative (PFI) in 2009. The hospital has approximately 1,053 inpatient beds, and has over 140,000 emergency attendances each year.

We undertook a unannounced focussed inspection at Queen Alexandra Hospital on 22 and 23 February and 3 and 4 March 2016. We inspected the Emergency Department (ED) and Medicine specifically the urgent medical pathway. At that time we found some patients in the emergency department (ED) were at risk of unsafe care and treatment and there were areas of poor practice where the trust needed to make improvements.

We considered that people who used the emergency services at Queen Alexandra Hospital would, or may be, exposed to the risk of harm if we did not impose urgent conditions for the Trust to provide a safe service to patients. On 15 March 2016, we took urgent action and issued a notice of decision to impose conditions on their registration as a service provider.

We asked the trust to take immediate action, under section 31 of the Health and Social Care Act (2008), and imposed four conditions on their registration. We told the trust to immediately ensure:

- A clinical transformation lead is appointed based on external advice and agreement, and ensure effective medical and nursing leadership in the emergency department.
- Patients attending the Emergency Department at Queen Alexandra Hospital are triaged, assessed and streamlined by appropriate staff, and escalation procedures are followed.
- The “Jumbulance” is not used on site at the Queen Alexandra Hospital, under any circumstances. The exception to this will be if a major incident is declared.
- CQC receive daily monitoring information that is to be provided on a weekly basis

On 29 and 30 September 2016 we undertook an unannounced and focussed inspection of the emergency care pathway at the Queen Alexandra Hospital. The focus of our unannounced inspection was on the actions the trust had taken as a result of the urgent conditions imposed on them to improve the identified risks to patients through their emergency care pathway. We inspected two core services urgent and emergency care and medical services.

Detailed findings

Our inspection team

Our inspection team was led by:

Inspection Lead: Caroline Bishop, Inspection Manager, Care Quality Commission

The team included two CQC managers, four inspectors and four specialist advisors, including two medical consultants both with extensive experience of working within the emergency care pathway, a head of emergency department nursing and a senior governance lead.

How we carried out this inspection

Prior to the inspection we reviewed the regular weekly performance metrics sent to us by the trust. We collated and discussed relevant information shared with us by the Emergency Care Improvement Programme (ECIP), Clinical Commissioning Groups, NHS England and NHS Improvement.

On September 29 and 30 2016 we undertook an unannounced and focussed inspection of Portsmouth

Hospitals NHS Trust. The purpose of this inspection was to follow up on the urgent conditions imposed on the trust under section 31 of the Health and Social care Act 2008 following our last in inspection on 22 and 23 February and 3 and 4 March 2016.

We spoke with patients, staff senior leads and the executive team. We observed care, interviewed staff and attended bed meetings.

Facts and data about Queen Alexandra Hospital

There were 141,957 attendances in the emergency department between April 2015 and March 2016.

28.0% of patients were admitted in 2015/16 compared with an England average of 21.6%

82% of patients were treated within four hours. However, this was less than the national standard of 95% and less than the England average of 90% in the same time period.

The percentage of patients being discharged from the department within four hours had increased from 73% in February 2016 to 82% in July 2016 (the latest date for which national figures are available). However, this was still less than the England average of 90%.

There were 54,519 hospital medical spells during April 2015 to March 2016.

The average length of stay for elective admissions was better than the England Average.

Trust performance for average length of stay for non-elective admissions was generally worse than the England average. Cardiology showed a slightly better average length of stay than the England average.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Urgent and emergency services

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

Information about the service

Queen Alexandra Hospital is the acute district general hospital of the Portsmouth Hospitals NHS Trust. The emergency department (ED) at Queen Alexandra Hospital is open 24 hours a day, seven days a week. It treats people with serious and life-threatening emergencies and those with minor injuries that need prompt treatment such as lacerations and suspected broken bones. There are approximately 137,000 attendances each year. The ED is a recognised trauma unit, although major trauma patients go directly to Southampton (the nearest major trauma unit).

The department has a four-bay resuscitation area, one bay is designated for children. There are two major treatment areas, one with 13 cubicles and the other with 18. There is a separate ambulance assessment area with room for two patient trolleys. There are three side rooms that can be used for patients with infectious conditions. The minor treatment area has four cubicles and a consultation room used by GPs to provide an urgent care service. The urgent care service was for patients that presented with a condition that required immediate treatment, but which could be carried out by a GP.

The department has a separate children's treatment area with its own waiting room.

There is a nine bedded observation ward known as the Emergency Decision Unit (EDU). This area is comprised of two 4 bedded wards and one single bedded side room.

We have inspected the emergency department three times since February 2015, the most recent inspection

taking place during February and March 2016. On each occasion we have found serious concerns regarding patient safety and the responsiveness of the service to the needs of the local population.

Following our inspection in February 2016 we rated the Urgent and Emergency service as Inadequate. As a consequence, we took urgent action to impose four conditions on the hospital. These were:

- To appoint a clinical transformation lead for the emergency care pathway based on external advice and agreement.
- To operate an effective escalation system which will ensure that every patient attending the emergency department is triaged, assessed and streamed by appropriately trained staff.
- To ensure the large multi-occupancy ambulance known as the "Jumbulance" is not permitted to be used on the hospital site and that ambulance waits do not exceed the recognised national target.
- To collect daily monitoring information on the above that is to be provided to the CQC on a weekly basis.

This inspection:

We undertook this unannounced focused inspection of the emergency care pathway at Queen Alexandra Hospital in order to assess the impact of the changes made following our last inspection. The inspection took place on 29 and 30 September 2016. During this inspection we spoke to approximately 30 members of staff, 8 patients and two relatives. We looked at 9 sets of care records as well as policies and other documents.

Urgent and emergency services

Summary of findings

Overall, we rated this service as requires improvement. This shows improvement as the overall rating given following our previous inspections in February 2015 and February to March 2016 was inadequate. Urgent and emergency services were rated as requires improvement for safe, responsive and well led, and good for caring and effective because:

- There had been improvements since our last inspection; however patients were still spending too long in the emergency department. There were delays caused by a lack of empty beds on wards which sometimes resulted in a crowded department. Evidence shows that patient safety is comprised in these circumstances.
- Infection control guidelines were not consistently adhered to across. For example there were areas within the resuscitation room that were not clean and had not been checked; this increased the risk of cross infection to staff and patients.
- There were occasions when patients had to wait outside in ambulances, although these were rare and for shorter periods of time than previously. We observed long delays before treatment was commenced by on-call specialist teams.
- Ambulance patients were sometimes left in a corridor with no-one observing them. Many improvements had been made regarding patient flow the department treated and discharged 82% of patients within four hours. However, this was less than the national standard of 95% and less than the England average of 90% in the same time period. There were delays of up to 48 hours for patients with mental health problems who needed to be admitted.
- Emergency department staff expressed doubts regarding the sustainability of recent improvements. Many of the improvements made recently had, of necessity, been reliant on external help and advice. Emergency department staff had been supported to make independent decisions about service improvements but this was at an early stage.

However:

- Significant improvements had been made since our last inspection in February 2016 when we had found the department to be inadequate.
- The vehicle known as the Jumbulance (a large multi patient use ambulance vehicle) had been removed.
- The department had submitted daily performance monitoring data to CQC and had started to use this in its own improvement reporting.
- A senior transformation lead had been appointed and was working with trust to make necessary changes.
- National clinical audits show that patient outcomes were better than many other hospitals.
- Staff in the department treated patients and their relatives with dignity, respect and compassion.
- There was a proactive frailty intervention team which worked seamlessly with emergency department staff.
- There were robust clinical governance arrangements with effective reporting to the trust board. Incident reporting and figures about delays in treatment now more accurately reflected emergency department activity.
- There had been increased staff engagement via lunchtime drop-in sessions and multi-disciplinary staff engagement meetings. This had helped to reduce the culture of “learned helplessness” that we had found during the previous inspection. Staff were able to be more pro-active in effecting positive changes in patient care.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement 

By safe, we mean people are protected from abuse and avoidable harm

We rated safe as requires improvement because:

- Patients that were waiting in the corridor outside the ambulance assessment area were not always supervised by staff. These patients also had no means of calling for assistance when staff could not see them. However, there were signs which explained to patients why they were waiting in a corridor and asked them to contact a member of staff if they required anything.
- Infection control procedures were not followed after the use of equipment in the resuscitation room.
- There was no evidence that emergency grab bags containing resuscitation equipment had been checked.
- There was no ligature assessment completed for the room that was used for assessing young people with mental health problems in the children's emergency department.
- There were areas within the resuscitation room that were not clean and had not been checked; this increased the risk of cross infection to staff and patients.
- Staff attendance at mandatory training did not consistently achieve the trust target of 85%. Many staff had not completed the appropriate level (level 3) of children's safeguarding training.

However:

- There were appropriate staffing levels for medical and nursing staff. The department was well supported by consultant staff in psychiatry, elderly medicine and critical care.
- There was a strong culture of reporting incidents and, on the whole, lessons were learnt from them.
- There was clear evidence that daily checks were made on equipment for resuscitation.

- Medicines, including controlled drugs were securely stored and managed correctly.
- The department had been reorganised and this had reduced the need for handovers between staff and improved the continuity of patient care.
- Records we reviewed were complete and were available to staff that needed access to them.

Incidents

- The trust reported no never events for the emergency department between August 2015 and July 2016. A never event is defined as 'A serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers'. The occurrence of a never event could indicate unsafe practice.
- Information from NHS Improvement showed that there were 92 serious incidents reported across the department between August 2015 and July 2016. Of these 86 were related to emergency preparedness, resilience and suspension of services.
- The department has increased its reporting of incidents. An incident 'trigger list' had been introduced for staff to clarify situations when they should submit a report.
- We saw evidence that staff received feedback and learning from incidents that had been reported. Staff we spoke with told us they felt safe to report incidents and near misses and understood the reasons why incident reporting should always happen.
- The clinical director was responsible for the department's clinical governance activities. This included mortality and morbidity meetings. These meetings happened monthly, and details of incidents and deaths were discussed and learning shared, minutes that we reviewed showed this.
- There was a process in place for the management of incidents that included the duty of candour. 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

Urgent and emergency services

person. Staff were aware of the duties required by the duty of candour. We saw examples where details of investigations had been shared with families that indicated duty of candour responsibilities had been fully discharged.

Cleanliness, infection control and hygiene

- Infection control practices were not always followed. In the resuscitation room the machine for blood gas analysis was splattered with blood, there were cleaning wipes stored nearby, but these had not been used. The sharps bin adjacent to the blood gas analyser was overfull and also externally splattered with blood. There was a risk that staff using the sharps container could contaminate their hands with blood. This was escalated during the inspection. The previous inspection found the area in the same state, so we were not assured that regular checks were being made.
- The department was clean and uncluttered, this was difficult to maintain due to ongoing building work during the inspection, to make changes to the layout of the department.
- We observed that staff washed their hands in between contact with patients. There were sufficient supplies of hand gels and personal protective (PPE) equipment, such as gloves and aprons for staff to use. We saw staff used PPE appropriately.
- Patients with potential infections were isolated from other patients in the major treatment area, and appropriate steps were taken to stop the spread of infection. Cubicles were deep cleaned when patients moved out of them.

Environment and equipment

- There were trolley spaces indicated on the walls of the corridor outside the ambulance assessment area. The space had signs which explained to patients why they were waiting in a corridor, and asked them to tell a member of staff if they needed anything. However, there were no call bells to summon help if no staff were present.
- In the children's ED, there was a quiet room for use with children or relatives. This was sometimes used for the assessment of young people with mental health problems. However, the room had not had a ligature

risk assessment and there were potential ligature points and an accessible trailing lead. This was discussed with senior staff during the inspection who took immediate action to improve safety.

- Resuscitation equipment was not being stored correctly to ensure it was ready for use. In the major treatment area and resuscitation room there were three emergency grab bags. Staff told us that they should have been sealed with a tamper proof tag to give assurance that the equipment had been checked and was ready for use. We found that one bag was not sealed and the other two had been sealed with a cable-tie that was difficult to remove. These contained the emergency equipment needed when transferring a critically ill patient to another area in the hospital. There were checklists contained within the bags but there were no records of checking contained within the grab bag to give staff assurance that the bag was fully stocked and ready for use.
- The layout of the department had changed since our previous inspection. Previously there was a major treatment area and a major treatment waiting area. Patients on trolleys could spend a number of hours in "major treatment waiting" before being moved to the major treatment area. There were now two separate major treatment areas where assessment and treatment could be completed. This meant that there was no longer a requirement to hand patients over to other nurses if the patient moved to the major treatment area. This improved the flow continuity of care for patients and reduced patient handovers.
- There was appropriate seating in the main waiting area, this area was overseen by streaming / triage nurse (navigator role).
- The ambulance assessment area was undergoing building works to allow room for more patients. During part of these works patients were assessed in a room adjacent to the ambulance entrance. However, we were not aware that a risk assessment had been undertaken to ensure staff and patient safety in this temporary area.

Urgent and emergency services

- The Emergency Decision Unit (EDU) was previously called the Observation Ward. This had two four bedded bays and a side room. This area was used for patients that required short term observation or were waiting for the results of tests.
- The department had access to hospital beds to allow elderly patients to be nursed on appropriate pressure relieving devices, such as alternating pressure air mattresses in the majors treatment area. We saw patients had been transferred onto beds with pressure relieving mattresses while waiting to be transferred to the AMU.
- During the inspection in February 2016 we found checks of resuscitation equipment were not carried out regularly, there were a variety of different checklist designs in use. On this inspection, there was a consistent system for checking equipment in the resuscitation room. We found that checks had been made daily
- Disposable equipment was stored appropriately and was found to be in date and suitable for use.
- There was a separate ambulance entrance for children and specially equipped resuscitation room.

Medicines

- Minimum and maximum temperature recordings of medicine refrigerators in the resuscitation room were carried out daily. They were all found to be in the expected range.
- Medicines stored in the department were spot checked and found to be in-date and stored securely. Controlled drugs were stored securely and appropriately. A review of the controlled drugs register found that medicines administered had been correctly completed and reconciled with the stock level.
- Patient allergies were recorded on the prescription charts we reviewed. There was a departmental protocol for the prescribing of antibiotics that staff adhered to.
- In the children's emergency department we found that medicines were securely stored in a locked room. There was a refrigerator for medicines that required temperature controlled storage, minimum and maximum temperatures were recorded daily. The

refrigerator was locked; it contained medicines required for rapid sequence induction of anaesthesia and was in a secure room. This meant that the drugs may not be accessible quickly in an emergency as staff would require the code to the room and the key to the refrigerator. There was no evidence that this potential risk had been considered.

Records

- When a patient was registered, their details were entered onto a computer system that showed how long people had been waiting and the investigations they had received. Patient records and information stored on computer was protected by passwords and backed-up to keep it secure.
- The department had staff known as patient 'trackers' who were responsible for printing off patient records from the electronic system to ensure they were complete and transferred with the patient. Clinical staff told us that this role was very valuable as it freed up their time to care for patients
- Staff entered all clinical information onto the computer system. When patients were admitted to a ward a paper copy of their treatment record was printed out and taken with them.
- We reviewed nine sets of patient records; these were complete and included observations and pain assessment scores.
- We saw that risk assessments for pressure ulcers and the use of bed rails were completed.

Safeguarding

- Staff were aware of how to make a referral to the trust safeguarding team and also the local authority. Staff were aware that there was a statutory reporting process in cases of female genital mutilation and could find this information on the hospital intranet if required.
- There was also information for staff about processes to follow if they suspected a patient had been subject to, or was at risk from domestic violence.

Urgent and emergency services

- Children's safeguarding and child protection arrangements were appropriate. Staff identified parental responsibility. The electronic system used across the department provided a template for staff to follow and record responses.
- Medical staff had completed training on adult and children's safeguarding. Hospital data from March to August 2016 reported that over 95% had completed safeguarding adult's level 1 and 83% children's safeguarding level 2. Forty four percent of medical staff had completed children's safeguarding level 3 as at August 2016.
- Of the 14 consultants in the emergency department, eight had completed the children's safeguarding level 3 training.
- Nursing staff had completed training on adult and children's safeguarding. Hospital data from March to August 2016 reported that over 97% had completed safeguarding adult's level 1 and over 92% children's safeguarding level 2. Fifty one percent of nursing staff had completed children's safeguarding level 3 as at August 2016.

Mandatory training

- Staff attendance at mandatory training did not consistently achieve the trust target of 85% between March and August 2016. Although the ED achieved the Trust target of 85% between March and August in Complaints and Claims, Dementia Care Awareness, Health, safety and Welfare, Moving and Handling level 1, Risk Management and Safeguarding Adults.

Assessing and responding to patient risk

- By September 2016, 90% of ambulance patients had an initial assessment within 15 minutes. This was a significant improvement compared to our last inspection when patients waited an average of an hour for an initial assessment.
- The ambulance service records any delays in patient handover of more than one hour (known as black breaches). This had happened on an almost daily basis at the beginning of the 2016 but our weekly monitoring has shown improvement in recent months. For example, in the first 18 days of September there were 40 black breaches. Although this is more than many other hospitals, it had improved since the first 18 days of April when the figure was 62 black breaches.
- Ambulance data showed that of ambulance turnaround times over 30 minutes, the proportions which were 60 minutes or longer increased between January and May 2016 to an average of 23%. This compares to a previous average of 9%.
- During the February 2016 inspection there was little evidence of a process of rapid assessment and treatment. The assessment of ambulance patients had been improved by introducing a rapid assessment and treatment process. During the day, this was carried out by a team which comprised a senior doctor and nurse and a healthcare assistant. The process needed to be carried out quickly in order that subsequent ambulance patients did not have to wait. During the inspection this area had two trolley spaces, so assessment was carried out rapidly in order to ensure space was available for incoming ambulances. To emphasise the need for speed, the process was called "Pit Stop".
- The department had introduced a role known as the navigator in the two weeks prior to the inspection. This was a significant change to the triage and streaming process. The navigator was a senior qualified nurse based in the main waiting room of the department. This nurse carried out a brief clinical assessment of patients as soon as they arrived and they were able to quickly reassess patients if they showed signs of deterioration. There was a panic button for the safety of the navigator nurse. There was not yet a documented operating procedure for the navigator role. However, there was a flow chart that was being amended based on feedback from the nurses undertaking the new role.
- The navigator nurse was able to stream patients directly to the major treatment area if needed, and also to minor treatment area and the minor illness service. The navigator nurse was able to book patients in and record basic observations, they moved patients directly to the resuscitation room or the 'Pit Stop' area if they felt this was clinically indicated. Patients we spoke with told us they felt the new navigator role was good and made them feel safer because they were able to discuss their concerns with a nurse.

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- The department used the national early warning system (NEWS) to detect patients that were at risk of deterioration. In records that we reviewed these were appropriately used. Staff felt able to escalate NEWS scores to senior nurses or medical staff and did so.
- Staff we spoke with demonstrated a good understanding of the needs of patients with complex needs. There was a specific assessment tool that helped to identify immediate treatment needs.
- The trust had performed better than the national standard for time to treatment (60 minutes) between June 2015 and May 2016. It had been similar to or better than the England average for the same time period.

Nursing staffing

- There were sufficient qualified nurses to staff the department safely. This was confirmed from staffing rotas.
- There was a safer staffing acuity tool in use to ensure there were sufficient staff. Where there were gaps in rotas this was escalated to the senior management team. There were no gaps in staffing noted during the inspection. Staff told us that gaps in staffing were filled on the whole and that the department had sufficient nursing staff.
- Senior nursing staff we spoke with told us that some newly recruited staff required a high level of supervision and support, but were optimistic about their potential.
- The nursing staffing of the department appeared on the risk register as there was a shortage of children's nurses to staff the children's emergency department. The service was not able to run over 24 hours and the children's service was run from the main department after 2am.
- Recruitment was being actively sought for children's nurses and emergency nurse practitioners.
- Handover procedures were observed and were robust giving an overview of activity within the department. However, handovers were conducted separately between medical and nursing staff. This meant that there was no single overview of the department or awareness of pressures or risk across disciplines.

Medical staffing

- The trust employed 47 whole time equivalent doctors. The department had 14.7 whole time equivalent consultants; this was above average for hospitals in England for medical staffing in the ED. There was a small group of senior doctors that were not consultants (15% of medical workforce) and a large group of middle grade and senior house officers that made up 54% of the workforce. again higher than the England average.
- There was a senior doctor on duty in the ambulance assessment area between 10am and 10pm every day.
- There was consultant cover in the department for more than 16 hours per day. This was in line with Royal College of Emergency Medicine recommendations on consultant workforce (2010) However; consultants told us that they were often not always able to leave the department at the end of their shift.
- We noted that there were several occasions during April and July when consultants had to work on their day off in order to maintain safe staffing levels.
- There were insufficient junior medical staff on the medical staffing rota due to vacancies. This made it necessary for consultants to 'act down' in order to fill these roles.
- The mental health liaison team provided a consultant psychiatrist that was based in ED.
- The Frailty Interface Team (FIT) had a consultant in elderly medicine that worked with the FIT team staff across the department.
- Staff from the intensive care unit were available at all times to assist in the resuscitation room should patients require urgent anaesthesia to support the ED medical staff. There were cover arrangements in place from on-call anaesthetists.

Major incident awareness and training

- There were security staff in the department at night, from 9pm-5am. These staff had received training in conflict resolution and physical restraint.
- The Emergency Department had an escalation policy (dated October 2016) that provided staff with guidelines for the delivery of safe and timely care for patients. The policy described best practice with regard to providing clinical capacity when the hospital

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was in escalation. This policy worked in conjunction with the Capacity Escalation Policy and the Full Capacity Policy. These policies were intended to work with the escalation policies throughout the hospital to ensure risk sharing could be achieved and the admission of patients into hospital beds in wards to enable the normal functioning of department. Staff had awareness of changes in escalation policies that had been made since the inspection in February 2016.

- The trust had agreed escalation plans across the Portsmouth system in May 2016.
- The department had an up-to-date major incident plan, and arrangements were in place with the local ambulance trust to manage mass casualties.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good



We rated effective as good because:

- The Royal College of Emergency Medicine (RCEM) audit showed that patient outcomes were better than many other hospitals. The rate of unplanned re-attendances within seven days was slightly better than the England average.
- There were easily accessible evidence based guidelines for the treatment of urgent and emergency patients.
- The department satisfied the requirements of the national “Standards for children and young people in emergency settings”.
- Patients’ pain was assessed promptly and appropriate pain relief was administered quickly.
- Teaching and staff development was a priority in the department. There was a structured competency framework for nursing staff.
- There was good multi-disciplinary working with the frailty intervention team, the psychiatric liaison team, the stroke unit and intensive care staff.

However,

- Admission avoidance referrals to the ambulatory care centre were inconsistent.

Evidence-based care and treatment

- The emergency department used a combination of clinical guidelines from the National Institute for Health and Care Excellence (NICE) and the Royal College of Emergency Medicine (RCEM) to determine the treatment that was provided. Guidance was regularly discussed at monthly governance meetings, disseminated and acted upon as appropriate.
- A range of clinical care pathways and proformas had been developed in accordance with guidance produced by NICE. These included treatment of strokes, asthma, feverish children, multiple trauma and the prevention of deep vein thrombosis. At monthly governance meetings any changes to guidance and the impact that it would have on clinical practice was discussed.
- The department satisfied the requirements of the national “Standards for children and young people in Emergency Care settings”.
- The ED participated in a number of national audits, including those carried out on behalf of the Royal College of Emergency Medicine (RCEM).
- There was also a local audit programme which included topics such as compliance with insulin prescribing, sepsis, trauma care and standards of record keeping. The results of the audits led to refinements and changes in treatment protocols and improvements in the clinical computer system. Updated protocols were shared with all staff the department.

Pain Relief

- We observed that nurses administered rapid pain relief when they assessed patients who had arrived by ambulance or on foot.
- During our inspection we observed timely pain relief administered to children. The results of the pain relief were monitored and additional treatment given if necessary.
- Although formal pain scores were not always assessed in the minor treatment area, three of the four patients that we asked told us that they had been offered pain relief. Records showed that this had been administered promptly and in line with hospital policy.

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- Pain scores were recorded in the major treatment and resuscitation areas as part of the national early warning system (NEWS).

Nutrition and hydration

- Following the assessment of a patient, intravenous fluids were prescribed, administered and recorded when clinically indicated. Intravenous drug charts showed that these were recorded completely and accurately.
- Patients that were allowed to eat while waiting in the major treatment areas were provided with sandwiches and snacks.

Patient outcomes

- The RCEM carried out three national clinical audits in 2015/16 and the ED at Queen Alexandra Hospital took part in all of them. The first was the measurement of vital signs in children. Standards at the hospital were similar to the majority of hospitals in England. Standards were better than most other hospitals in the prevention of blood clots in immobilised lower limbs and procedural sedation in adults. In the latter audit the completion of safety documentation before discharge was significantly better than the majority of hospitals in England (82% of patients compared to 3%).
- In the previous year the department had achieved better results than the majority of hospitals in clinical audits regarding initial management of the fitting child, mental health in emergency settings and the assessment of cognitive impairment.
- We observed two patients with sepsis being treated promptly and in accordance with national guidelines.
- There was a local audit programme which included topics such as compliance with insulin prescribing, sepsis, major trauma and examination of feverish children. The results of the audits led to refinements and changes in treatment protocols and improvements in the clinical computer system. Updated protocols were shared with all staff the department
- The department was currently contributing to three national research projects regarding the treatment of head injuries, heart failure and childhood sepsis.

- The rate of unplanned re-attendances within seven days is often used as an indicator of good patient outcomes. At the Queen Alexandra hospital unplanned re-attendances were 7.5% since August 2015 against the national average of 8%.

Competent staff

- Appraisals of both medical and nursing staff were being undertaken and staff spoke positively about the process. At the time of our inspection 80% of nursing staff had taken part in an appraisal in the last year against a target of 85%. Nurses explained that, when the department became crowded, all “office activities” were cancelled to enable staff to look after patients. The head of nursing was aware of the shortfall and had arranged appointments for outstanding appraisals.
- Teaching and staff development was a priority in the department. Nursing shift times were flexible in order to allow for formal teaching sessions two or three times a week.
- Staff told us that there was a structured competency framework so that nurses and their managers knew when they were ready for increased levels of responsibility. These had recently been updated in order to reflect changes in practice.
- We spoke with doctors who were new to the department. They told us that they received regular supervision from the emergency department consultants, as well as twice weekly teaching sessions.
- Nurses we spoke with told us that they had undertaken the Resuscitation Council’s Intermediate Life Support course and others had also attended paediatric resuscitation training.
- Nursing staff were supported by an ED practice educator who was a senior member of staff who also worked clinically. This role co-ordinated the activities of student nurses within the department and helped to develop competency assessments for qualified staff.
- A recent education audit by the University of Southampton and the Nursing and Midwifery Council had shown that the department provided a supportive and well-informed learning environment.
- Physicians working in ED were supported with the maintenance of anaesthetic skills by staff in the intensive care unit.

Multidisciplinary working

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- Medical, nursing staff and support workers worked well together as a team. There were clear lines of accountability that contributed to the effective planning and delivery of patient care.
- There was a good working relationship with the children's safeguarding team and with the community paediatric team.
- The psychiatric liaison team had recently been expanded by the NHS trust that provided the service. The team consisted of nine mental health nurses and a consultant psychiatrist. We observed a good working relationship between this team and ED staff. ED nurses told us that the emergency mental health pathway was now more effective and patients did not wait so long to be seen. We did not find any unattended patients with mental health problems in the department as we had done previously.
- The mental health liaison team also assessed patients who had attended as a result of substance or alcohol misuse.
- The two main pathways for avoiding unnecessary admissions were referrals to the ambulatory care centre and to the frailty interface team (FIT).
- Referral criteria for ED patients that could be treated in the Ambulatory Care Centre was not well established. Referral rates in the six weeks prior to our inspection had varied from 25 patients a week to 49 patients which were similar to the numbers on our previous inspection. An ED doctor told us that acceptance of referrals depended on the type of staff working in the Ambulatory Care Centre on any given day. We later learnt that nurses and doctors rotated from the Acute Medical Unit and that their number and experience was variable.
- The frailty interface team was comprised of clinical nurse specialists, healthcare support workers, occupational therapists, physiotherapists and a consultant in elderly medicine. The team carried out a specialist assessment of all frail elderly patients attending the department. They worked closely with clinical and support teams in the community in order to prevent the need for hospital admission. We observed a very proactive approach from the team. There were computer screens in their office which showed details of patients in the department and those that were

expected to arrive by ambulance. This enabled the team to assess frail patients as soon as they arrived and they were able to suggest and discuss treatment options with ED staff.

- Staff we spoke with reported that integration with the rest of the hospital had improved in recent months. Other specialties were beginning to accept that effective treatment of emergency admissions required action from a number of different hospital teams, not just those in the emergency department.

Seven-day services

- The department had access to radiology support 24 hours each day, with rapid access to CT scanning when needed.
- There was an on-call pharmacy service outside of normal working hours.
- Emergency department consultants provided cover 24 hours per day, 7 days per week, either directly within the department or on-call.
- The new psychiatric liaison service worked seven days a week from 8am to 8pm.
- There was always an anaesthetist on-call to assist with resuscitation if required.

Access to information

- Information needed to deliver effective care and treatment was well organised and accessible. Treatment protocols and clinical guidelines were computer based and we observed staff referring to them when necessary.
- The computer system alerted staff when vulnerable children or adults arrived in the department.
- Discharge letters were clear and comprehensive and were sent to GPs on a daily basis.
- The computer systems provided up-to-date information about patients' condition, investigations and progress within the ED.
- Computer systems in the department were protected by password to prevent unauthorised persons accessing patient information.
- There were several whiteboards in the major treatment area, these identified patients by initials only and recorded the patients whereabouts in the department. The boards were also used for staff allocation and the progress of any investigations or tests that patients needed.

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Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed that consent was obtained for any procedures undertaken by the staff. This included both written and verbal consent.
- Consent forms were available for people with parental responsibility to consent on behalf of children.
- The staff we spoke with had sound knowledge about consent and mental capacity and knew when formal mental capacity assessments needed to be carried out.
- Where patients lacked the capacity to make decisions for themselves, such as those who were unconscious, we observed staff making decisions which were considered to be in the best interest of the patient. We found that any decisions made were appropriately recorded within the medical records.

Are urgent and emergency services caring?

Good 

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

We rated caring as good because:

- We observed patients and those close to them receiving compassionate care from staff across the emergency department.
- The emergency department (ED) staff were welcoming, and did all they could to provide patients with privacy when booking in. We witnessed staff treating distressed patients with kindness and compassion.
- Staff in the department treated patients and their relatives with dignity and respect. Consent was sought from patients before staff carried out observations, examinations or provided care. Staff met the needs of patients promptly.
- Emotional support was provided for patients and their relatives in the department. There was a room that

could be used to accommodate the relatives of critically ill patients brought into the major treatment area' area or resuscitation room. Whilst in this room, staff told us that families were given regular updated information.

- The chaplaincy team were available over 24 hours, and were able to provide additional support for patients and their relatives.

However,

- Patients' conversations with the navigator nurse could be overheard by other patients in the waiting room.

Compassionate care.

- We observed caring interaction from the navigator nurse when they took details from three adult patients and four children (and their families). Two patients commented that they felt the navigator system was better than previous processes. They felt reassured by their discussions with the nurse and said they felt happier than on previous visits when this role was not in place.
- The CQC A&E survey 2015 showed that the trust performed similar to other trusts for the question about how long it took for a patient to speak to a nurse or doctor.
- The A&E survey results from 2015 in response to the question about privacy and dignity, rated the department about the same as other trusts'.
- Patients were treated with dignity and respect, where possible staff tried to maintain confidentiality of conversations. However, due to the layout of the department, particularly in the major treatment area with chairs this was difficult. Staff were aware of this and spoke quietly to patients when receiving information about their reasons for attending the department.
- We noted that there was no area for patients to have a confidential conversation with the navigator nurse. However, this had been identified and a separate screened area was being considered.

Understanding and involvement of patients and those close to them

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- Family members were allowed to stay with their relatives in the resuscitation room if this was appropriate and were given information and supported by staff. Relatives waiting with patients in the major treatment area were given drinks.
- Data from the A&E survey (2015) for the question relating to patient confidence and trust in the doctors and nurses in the department was about the same as other hospitals. Patient also rated the ability to get attention from a member of staff if they needed something the same as other trusts’.
- Patients told us that they were involved in decisions about their care and treatment as much as they wanted to be.

Emotional support

- We saw emotional support given during the observations and triage of a lady with a pregnancy related illness. The nurse explained all procedures that were required to ensure a referral to the gynaecology service was accepted.
- Clinical nurse specialists attended the department from various teams within the hospital. We saw supportive interaction with patients from nurse specialists in the palliative care team. The frailty interface team were based in the department and were able to provide support to elderly and frail patients.
- For patients with mental health crises, the hospital mental health liaison team were based in the department. Staff told us that access to this service had improved since the last inspection in February 2016.
- Staff had access to the hospital chaplaincy team and could contact them at any time to support patients with religious or cultural needs as well as provide emotional support.
- The A&E survey results for the question about staff responding to patients being distressed rated the department about the same as other trusts.

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

(for example, to feedback?)

Requires improvement



We rated responsive as required improvement because:

However,

- Many improvements had been made regarding patient flow the department treated and discharged 82% of patients within four hours. However, this was less than the national standard of 95% and less than the England average of 90% in the same time period.
- There were still occasions when patients had to wait outside in ambulances but these happened less frequently and for shorter periods of time than previously.
- We observed long delays before treatment was commenced by on-call specialist medical teams.
- There were delays of up to 48 hours for patients with mental health problems who needed to be admitted.
- The trust had implemented an urgent care improvement programme that had started to improve patient flow through the department.
- The department no longer used a multi-patient ambulance (“Jumbulance”) for patients waiting to be assessed and treated.
- Staff were knowledgeable about the care and treatment of patients with complex needs. They were committed to meeting those needs.
- Learning from complaints was discussed at clinical governance meetings and disseminated to staff via the governance newsletter.

Service planning and delivery to meet the needs of local people

- Changes had been made in the delivery of care to meet the needs of local people. Senior staff had visited other, well performing, emergency departments in order to understand how different ways of working could enhance patient safety and experience.
- The layout of the department had changed since our previous inspection. Previously there was a major

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treatment area and a major treatment waiting area. Ambulance patients had been passed from an assessment team, to the team in the major treatment waiting area and, eventually to a third team in the major treatment area. This was confusing for patients and we found that important clinical information was not always handed over between teams. Patients on trolleys could spend a number of hours in “major treatment waiting” before being moved to the major treatment area. There were now two separate major treatment areas where assessment and treatment could be completed. This meant patients who needed to be treated in the major treatment area no longer had to wait for hours in the major treatment waiting area and care and treatment would be delivered and completed by the same team of staff. This had improved safety, efficiency and the patient experience.

- Building works were taking place to enlarge the ambulance assessment area. In future this area, to be known as PITSTOP, would have room for six patient trolleys and four chairs. It was anticipated that this would prevent ambulance patients having to wait in a corridor.
- The function and structure of the previous urgent care centre had been changed to improve efficiency. The total number of staff had been reduced but there was now a dedicated GP (with a minimum of five years' experience) every day from 10am to 10pm.
- The trust had implemented an urgent care improvement plan that improved patient flow through the department. This had helped to reduce the severe crowding that had previously taken place. An example of the new arrangements was that medical patients, whose admission had been arranged by a GP, went directly to the acute medical unit, rather than being assessed and treated in the emergency department.
- There was now a hospital escalation policy which described the actions to be taken if the emergency department was full and ambulances were no longer able to handover patients. The policy was detailed and logical and ED staff were aware of the current escalation status.
- The department no longer used a multi-patient ambulance (“Jumbulance”) for patients waiting to be assessed and treated.

- There was full level access with automatic doors and, toilets with disabled access. Baby changing facilities were available within the children's emergency department.

Meeting peoples individual needs

- The waiting room had sufficient seating for the people waiting. Children had their own waiting area which included appropriate toys, and was accessed via a secure door operated by reception staff.
- There was a spacious relative's room that could be used for family members of critically ill patients in the resuscitation room.
- Patients admitted to the emergency department that were likely to die were relocated to a side room, to allow families to spend time with the patient. During the inspection a patient that had died remained in a side room in the department to allow further family members to get to the hospital.
- There was a lack of privacy for ambulance patients when they were waiting in a corridor before being transferred to a treatment area. However, we saw staff making every effort to ensure that corridor waits were as short as possible. Patients spent less time in the corridor than during previous inspections.
- Nurses had received training in the care of people with a learning disability. They were able to speak confidently about the differing needs of people with a learning disability and prioritised their care where possible.
- The majority of staff had recently undertaken training in the specific needs of people living with dementia. All patients over the age of 65 were assessed for signs of dementia. If they were found to be vulnerable they were referred to a specialist team before being discharged.
- We observed the care of a patient that had been admitted from home by the out of hour's service. However, on arrival in the department it was identified that they had a do not attempt cardio-pulmonary resuscitation in place as well as an advanced directive stating that they wanted to die at home. There was effective coordination between the FIT team, social services and the palliative care team which ensured the patient was discharged into the care of the community team that allowed them to die in their place of choice.
- There was a well-equipped and designed children's emergency department that was secure and separate from the adult area. This included areas for children to wait with age appropriate toys and also allowed

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observation of children with head injury. Treatment rooms for triage and treatment of children were also separate from adult facilities. This had a secure door from the main waiting room that was controlled electronically.

Access and flow

- Emergency departments in England are expected to ensure that 95% of their patients are admitted, transferred or discharged within four hours of arrival. This standard had not been met in any month at Queen Alexandra hospital since November 2013. In recent months the trust had changed working practices in order to reduce the amount of time that patients spent in the department. The percentage of patients being discharged from the department within four hours had increased from 73% in February 2016 to 82% in July 2016 (the latest date for which national figures are available). However, this was still less than the England average of 90%.
- On 22 September 2016, 95% of patients did spend four hours or less in the department. This was the first time in over 18 months. Senior hospital managers stated that this was because there were empty beds in the hospital at the beginning of the day. As a consequence, there were no delays in admitting patients from the emergency department.
- Although delays in admitting patients to a ward had been reduced a significant number of patients had to wait for many hours. In September 2016, 12% of patients had waited for between six and twelve hours.
- Data showed that the numbers of patients waiting for between 4-12 hours had been reducing. However, there had been 77 patients that had waited over 12 hours for admission from the time a decision to admit had been made from June 2015 to June 2016.
- Some patients had to wait for specialist doctors to see them before they could be admitted. We observed long delays in responses from surgical and medical specialists during our inspection. However, because these doctors do not use the ED computer system their arrival time in the department was not recorded. As a result, it was not possible to assess the scale of this problem.

- Delays in specialist assessment and care for patients with mental health problems had been reduced due to an increase in the number of psychiatric liaison nurses (provided by another NHS trust). However, there were sometimes delays if mental health patients needed to be admitted. One patient awaiting admission to a mental health unit had been in the department for over 48 hours. They were nursed in the emergency decision unit and were cared for by ED nurses with input from the mental health liaison service.
- The children's emergency department was open between 7am and 2am. Outside of these hours the service consolidated to the main department.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. If a patient or relative wanted to make an informal complaint they were directed to the nurse in charge of the department. If the concern was not resolved locally, patients were referred to the Patient Advice and Liaison Service (PALS), formally logged their complaint and attempted to resolve their issue within a set timeframe. Contact information for PALS was available within the main ED.
- Formal complaints were investigated by a consultant or senior nurse and replies were sent to the complainant within an agreed timeframe. Numbers of complaints and learning points from them were discussed at ED governance meetings. For example, patient comfort rounds had recently been changed to hourly, rather than two hourly.

Are urgent and emergency services well-led?

Requires improvement 

We rated well-led as required improvement because:

- Many of the improvements made recently had, of necessity, been reliant on external help and advice. Emergency department staff had been supported to make independent decisions about service improvements but this was at an early stage.

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- There had been several changes to the team leading the emergency care pathway in the last 18 months. As such, there was little sense of joint working or common purpose.
- Long-standing members of staff had doubts about the sustainability of recent improvements in patient flow and safety.
- Serious incidents and risks were escalated to the trust board but the quarterly governance report dated August 2016 did not demonstrate that analysis or effective action had taken place as a result.

However,

- A clinical transformation lead (Director of Emergency Care) had been appointed and had begun to implement an urgent care improvement programme. There was an acknowledgement that successful treatment of emergency admissions required action from a number of different hospital teams, not just those in the emergency department
 - There was increased strategic focus at trust board level on the improvements needed in the emergency care pathway. Emergency department leaders described increased support from board members.
 - There had been increased staff engagement via lunchtime drop-in sessions and multi-disciplinary staff engagement meetings. This had helped to reduce the culture of “learned helplessness” that we had found during the previous inspection. Staff were able to be more pro-active in effecting positive changes in patient care.
 - Proactive clinical governance was led by the chief of service. A quarterly clinical governance newsletter was detailed and informative.
- All reported that they had received increasing levels of support from senior staff in the trust in recent months. In the written foreword to the urgent care improvement programme document, the interim chief executive made it clear that all staff in the trust needed to work together in order for the programme to be successful.
 - There had been two different heads of nursing in the ED over the last two years. In addition, a new matron had been appointed in January 2016. As a consequence nursing leadership was not well established. Nurses expressed respect for the matron and head of nursing and told us that they were approachable and supportive.
 - The general manager had been in post for five months but had a good understanding of the challenges facing the department and the improvements that were required.
 - The chief of service was clinically active and we observed him providing clinical leadership on a daily basis. Doctors and nurses confirmed that he had the skills, knowledge and experience required to lead the department.
 - We observed a good rapport between the director of emergency care and senior staff within the ED. Some staff expressed a feeling of optimism that the new role would “make things happen”.

Vision and strategy for this service

- An urgent care improvement programme (UCIP) had been agreed by the trust board. There was a sense of determination from the leaders of this programme that it would be adhered to and that any obstacles would be overcome. This was a departure from the situation we had found during our previous inspection in February 2016, when the trust was attempting the implementation of the third new model of emergency patient flow in 12 months.
- Work had begun with different specialties throughout the hospital to involve them in the improvements needed when patients required emergency admission.

Leadership of service

- A clinical transformation lead (Director of Emergency Care) had been appointed following external advice and agreement; they had taken up the newly-created post in July 2016.
- The emergency department leadership team consisted of the chief of service (a senior consultant), head of nursing and general manager.

Urgent and emergency services

- Senior staff in the emergency department acknowledged that the UCIP was not a long term strategy. However, it was an essential step that needed to be implemented before a longer term strategy could be devised.
- A risk summit held in September 2016 reported that improvements in the emergency care pathway were beginning to take place and that the trust had started to work effectively with external advisers.
- Staff told us that they felt respected and valued by their colleagues and the leadership team within the ED.
- There was a strong sense of teamwork which was centred on the needs of patients and their families. Staff told us that the support that they received from their colleagues helped them cope with the pressure which resulted from a department that was often severely crowded.
- During our last inspection staff had described a culture of “learned helplessness”. In recent months managers from the emergency care improvement programme had arranged staff engagement sessions where staff had been supported to make decisions that would improve patient care. At one session nurses had identified that frequent movement of patients from the ambulance assessment area to the major treatment waiting area and, ultimately, to the major treatment area was upsetting for patients and reduced safety. A healthcare assistant suggested that the major treatment waiting area could be changed to a second treatment area so that patients care was always managed by the same team. Other staff agreed with this proposal and managers supported it. The change took place within a month.

Governance, risk management and quality measurement

- The interim chief executive chaired a weekly urgent care improvement meeting. This examined the impact the urgent care improvement plan was having on the quality and safety of patient care.
- Detailed information about waiting times and patient safety in the emergency department was collected in real time and presented to board members on a weekly basis. The data (including ambulance waiting times, initial patient assessment, delays in treatment and admission to a ward) accurately reflected patient flow through the emergency department.
- When patients waited more than 12 hours for admission following a decision to admit staff, in the emergency department reported it as a serious incident. The trusts quality report, dated 11 August 2016 noted that there was an increase in these serious incidents in April and May 2016.
- Monthly governance and quality meetings were held within the department and these were well attended. Complaints, incidents, audits and quality improvement projects were discussed. We saw that governance issues were discussed at consultants meetings although not at Sisters or nurses meetings. This meant there was a risk that nurses would not be aware of current governance and safety issues.
- The ED chief of service published a detailed quality and governance newsletter once a quarter. It contained items such as learning from incidents, safeguarding alerts and compliance with infection control measures. The newsletter was posted on the staff noticeboard and was sent to each member of staff by e-mail.
- Staff supported each other on a day-to-day basis. However, they reported there had been little opportunity in the past to sit down together in order to develop improvements in patient care. Managers had recently addressed this issue by arranging multi-disciplinary staff engagement sessions. Originally facilitated by members of the NHS emergency care improvement programme, these sessions were now led by hospital staff.
- We asked a number of ED nurses and doctors if they thought that recent improvements in patient flow through the department would be continued, and if they were optimistic about the future. Staff that were relatively new was optimistic and enthusiastic about the changes. Staff that had been in post for several years were more cautious. They explained that they had been through a series of new ways of working in the last few years. Even when patient flow had improved initially, improvements had rarely lasted for long. They felt that it was too early to say whether the latest changes would become embedded throughout the hospital.

Culture within the service

Public engagement

Urgent and emergency services

- Public engagement was not assessed during this focused inspection.

Staff engagement

- During April and May 2016 the ED chief of service had held lunchtime drop-in sessions so that staff could discuss which practices worked well and which needed to improve. We were told that the results of these sessions were used to inform more in-depth staff engagement sessions.
- The multi-disciplinary staff engagement sessions which had taken place in the summer had led to smaller staff groups developing new ways of working in clinical areas. This had led to safety and patient flow improvements for patients brought by ambulance and those who arrived independently.
- The trust had recently introduced a simple monthly staff satisfaction “temperature check”. For one day a month staff recorded whether they felt positive or

negative at the beginning, during and at the end of their shift. Results for August (sent to us after the inspection) showed that ED staff felt negative during and at the end of the shift, even if they had felt positive at the beginning. Results for September were not available at the time of writing.

- Letters of thanks and praise for staff were displayed on the staff noticeboard. Excerpts from some letters were published in the governance and quality newsletter.

Innovation, improvement and sustainability

- Since our last inspection there had been a marked improvement in patient safety and patient flow through the emergency department. However, some ED staff we spoke with had doubts about the sustainability of the improvements during the winter months. Trust leaders were aware of these doubts and expressed determination to continue and develop the positive changes that had taken place.

Medical care (including older people's care)

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

Information about the service

We carried out this unannounced focussed inspection at The Queen Alexandra Hospital Portsmouth (part of Portsmouth Hospitals NHS Trust) on the 29 and 30 September 2016.

The purpose and focus of this inspection was to identify improvements in the urgent medical pathway for patients after they had been admitted from the Emergency Department into the Acute Medical Unit (AMU) and the wards.

Medical services at The Queen Alexandra Hospital had previously been inspected as a whole from 10 to 13 February 2015, at which time medical services were rated overall as requires improvement. A further focussed inspection of the urgent medical pathway was carried out on 22 and 23 February 2016 and overnight on 3 to 4 March 2016, at which time the overall rating for the urgent medical pathway was requires improvement.

Summary of findings

Overall we rated medical services as “requires improvement”. Medical services were rated as inadequate for well led and requires improvement for safe, effective, caring and responsive. This demonstrated a deterioration in the service since the previous inspections in February 2015 and February to March 2016.

- Strategies designed to improve the urgent medical pathway were not yet fully embedded and meeting their planned expectations. Culture of the consultant body and the hospital did not support effective change of the urgent medical pathway. Lack of medical staff allocated to escalation areas and the winter pressures ward, had a detrimental effect on patient flow through the hospital.
- Leadership on AMU was medically driven, with minimal input from the nursing team. Staff in some wards and clinical areas felt the senior management team was disengaged from them, their views were not listening to and they felt they were just left to “get on with things.” Staff felt demoralised by continued lack of improvements in the urgent care pathway. However, we did see there was good local leadership in some clinical areas.
- Governance processes were not effective at identifying risks and improving safety and quality of services provided.
- Systems, processes and standard operating procedures were not always reliable, consistent or

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appropriate to keep people safe. In AMU and on the medical wards, infection control procedures were not consistently followed. Medicines management in AMU and on the wards did not always follow the trust procedures and did not protect the wellbeing of patients. On AMU confidentiality of patient records was not always maintained and some patient records across all clinical areas were difficult to read.

- Care and treatment was inconsistent within the AMU. Some patients did not receive care based on assessment of risk or plans were not developed to support identified risks. Patients and their representatives were not routinely involved in planning and decision making processes about their care and treatment.
- Most patients had assessments for pain throughout their hospital stay, but staff did not consistently monitor the effectiveness of pain relief. In AMU patients did not always receive the support they needed at meal times because assessments had failed to identify the support they required.
- The trust was failing to meet its target for staff completion of annual appraisals for staff working in AMU and with the urgent medical pathway. The trust almost met their target of 85% compliance with mandatory training for staff working in the AMU and with the urgent medical pathway. When some escalation areas were open, staff felt they did not always have the necessary skills to care for some patients.
- We noted breaches of mixed sex accommodation on day units where medical outliers were. The trust had not considered these as mixed sex breaches.
- We witnessed care practices that showed empathetic and compassionate care was not always provided to patients.
- Patients were frequently moved which affected the timeliness of discharge. Some patients had multiple bed moves and were moved at night. Data showed there had been no improvements in the frequency of

patient bed moves since the last inspection. However, systems were in place, which ensured medical outliers were tracked and reviewed on a daily basis.

- Patients did not have access to timely discharge from hospital. The number of patients experiencing a delayed discharge had increased since the last inspection. Consultants and senior managers did not show drive and innovation to promote the access and flow of patients through the hospital.
- Strategies designed to improve the urgent medical pathway were not yet fully embedded and meeting their planned expectations. Lack of medical staff and therapists allocated to escalation areas and the winter pressures ward, had a detrimental effect on patient flow through the hospital.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement



By safe, we mean people are protected from abuse and avoidable harm. We rated safe as 'requires improvement' because

- Staff did not report all incidents that had potential to harm patients
- Safety thermometer information was collected, but not readily visible on AMU, to inform the patients or visitors to the hospital.
- Infection control practices were not consistently followed. Staff did not always use personal protective equipment (PPE) when delivering care or treatment to patients. Equipment was not always clean. Several sharps boxes were overfull, presenting risk of injury and cross infection to staff.
- There was a risk that emergency equipment was not available and ready for use. Daily checks of this equipment were not consistently completed. When completed, checks did not identify broken equipment. On the cardiac day unit (CDU), records showed all the cardiac monitors were overdue a service by three months.
- Management of medicines did not protect the wellbeing of patients. Medicines reconciliation was not always carried out in a timely manner. Nursing staff did not always follow the trust's policies and procedures and the Nursing and Midwifery Council's (NMC) standards for safe administration of medicines.
- Induction processes for agency staff was variable and not robust.
- Management of records did not always protect confidentiality of patient information. On one ward, patient details were displayed on a white board in full view of visitors. On AMU a computer screen with patient details was left open with no staff in attendance. Handwriting on some records across all clinical areas was difficult to read.

- Patients did not routinely have robust, individualised care plans to enable staff to plan and deliver their care and treatment appropriately and mitigate any identified risks.
- There was risk that medical staff would not attend to patients in a timely manner by medical staff in some areas because of insufficient medical cover. Staff reported there was no allocated medical team to some areas routinely used escalation areas (pink area on AMU and winter pressures ward).
- There were concerns about the resilience of the urgent medical pathway. At the time of the inspection all available escalation areas were open which meant there was limited capacity for further patients to be admitted.

However,

- Morbidity and mortality meetings were held to promote learning from complications and errors during care and treatment of patients.
- Staff demonstrated a good understanding about the Duty of Candour legislation and this was appropriately followed.
- General medicines were stored securely.
- Patient's paper records were stored securely.
- Staff had a good understanding of safeguarding procedures and the action they needed to take if they identified safeguarding concerns.
- Individual clinical areas were developing business continuity plans relevant to their own areas.

Incidents

- Information provided by the trust as part of the daily monitoring for the period 12 September to 3 October 2016 showed there were 63 incidents reported in AMU. Of these, 61 were reported as causing low harm to patients and two caused moderate harm to patients. The monitoring demonstrated a total of seven incidents caused severe harm to patients and were reported between March and October 2016 in AMU.
- There was a process for reporting incidents and staff told us they used the trust's incident reporting system. However, there were mixed views and experiences by staff about feedback from reported incidents. Staff

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working on the cardiac day unit (CDU) told us they rarely received feedback from incidents they reported. However, we saw “safety learning” posters were displayed to support staff to access shared learning from incidents.

- Following the last inspection the trust was required to provide data to the CQC on the number of incidents reported as occurring in AMU. This included near misses as well as incidents resulting in low, moderate or severe harm to patients. The data showed an overall increase in numbers of incidents reported between 27 March 2016 and 10 October 2016 resulting in low harm to patients and a decrease in the number of incidents reported resulting in severe harm to patients. However, there were no near misses reported at all during the three periods analysed. This suggests an element of a poor reporting culture. Discussions with staff indicated incidents reports were not always made for staffing concerns. This meant the trust could not monitor how frequently there were potential risks to patients.
- During the inspection, we found that not all incidents in AMU were reported and staff were unsure who was responsible for reporting the incident. However, staff confirmed the trust's incident reporting system was used to report incidents. During the inspection, we identified medicines administration documentation errors that had the potential to cause harm to patients and staff did not report these as incidents. These were incidents that should be reported as they may be classed as low harm. Staff on CDU told us they no longer reported medical outliers as incidents as this was now considered by the trust as normal practice. The trust told us, incidents relating to medical outliers were reported where staff felt the outlying was inappropriate or where an incident, such as a fall, happened to a patient who was an outlier.
- Records of governance meetings provided by the trust showed they reviewed incidents. However, the records detailed that the trust identified there were difficulties in learning from incidents as many incidents continued to show similar themes, such as lack of assessments and documentation processes in place.
- Records provided by the trust showed different departments in the medical services held mortality and morbidity meetings. (Mortality and morbidity

meetings are peer reviews of actions taken during the care of patients with the objective to learn from complications and errors and to prevent repetition of any errors leading to complications.) There was mixed detail in these records. Some evidenced learning that occurred as a result of the review, others just stated clinical facts and actions with no detail of any analysis of the event or possible learning.

- Senior nursing staff demonstrated a good understanding of the Duty of Candour legislation. 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. Staff were not able to provide with any examples to demonstrate the trust was meeting this requirement. Junior nursing staff had an understanding that duty of candour legislation related to transparency and telling the patient if you made a mistake, but they did not know whose responsibility it was to carry out the process.

Safety thermometer

- The trust collected safety thermometer data in relation to care provided to patients. The NHS safety thermometer is a monthly snapshot audit of the prevalence of avoidable harms. It also provides a means of checking performance and is used alongside other measures to direct improvement in patients' care. This included pressure ulcers, falls, Venous Thromboembolism (VTE) and catheter related urine infections (UTI).
- In AMU, despite the trust collecting the data, we did not see any safety thermometer results displayed. This meant visitors and staff were not informed of the results. Staff on AMU told us they were not aware of the results and there was no evidence that the results were used to effect learning and protect patients from harm.
- We reviewed the safety thermometer data available nationally. This showed that for the whole hospital for the period November 2015 to November 2016 94% to 96% of patients received harm free care. There was no indication that avoidable harms were increasing or

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decreasing across the hospital. Although, we did not have safety thermometer information that was specific to AMU or the emergency medical pathway, this was collected by the trust.

Cleanliness, infection control and hygiene

- At the previous inspection in February and March 2016 we identified staff did not always follow the trust's infection control policies and procedures to safeguard patients from the risks of cross infection. Following the inspection, the trust was issued with a requirement notice with regard to infection control practices. This required them to provide a report to the CQC about the actions they were taking to achieve compliance with the regulation associated with cleanliness, infection control and hygiene.
- The trust's action plan detailed there would be improved compliance with infection control practices and audit results by 30 June 2016. This included focussed education from Infection Prevention Control team to improve knowledge and education of staff by 18 July 2016. Weekly internal hand hygiene audits and monthly peer review audits (including hand hygiene practices and cleanliness of the environment to demonstrate sustained compliance with the trust's infection control policies.
- Infection control audits for AMU for August 2016 showed that only two areas in AMU achieved full compliance with the weekly infection control checklists. Compliance of nursing staff with the trust hand hygiene policy met the trust's target of 95%.
- Medical staff had not submitted any data for the first two weeks of August 2016 and for the third week in August; the data showed they were only 83% compliant with the trust's hand hygiene policy. This did not meet the trust's target of 95% compliance.
- Hand hygiene audits for the general medical wards, for June, July and August 2016, showed that overall compliance with hand hygiene policies was above the trust's target of 95%.
- Observations at the time of inspection showed that not all staff complied with the trust's infection control policies. We saw nurses in orange and lilac areas of AMU administering injections to patients without wearing gloves. We observed staff carried bedpans without wearing gloves or aprons. We observed some nurses did not wash their hands after removing gloves. Staff did not wear personal protective equipment (PPE) when they made beds and when disposing linen which may be infected. One resuscitation trolley was dirty.
- On a trauma and orthopaedic ward that also had some medical outliers, we saw equipment was not clean. The sluice was overcrowded with linen and commode seats were kept on the floor. Some commodes had yellow and brown marks on them and were not clean. Staff told us commodes should be cleaned after each use. However, the ward did not use "I am clean" stickers to identify when equipment was last cleaned. This meant there was no assurance that staff and patients were using clean equipment. We saw equipment, such as frames, hoists and stand aids were not clean and dusty
- In several areas, Lilac and Orange areas of AMU and CDU, we found sharps boxes that presented a risk of cross infection. On the lilac area of AMU, a large sharp's box was open, overfilled accessible to unauthorised people. The size of the opening meant people could put their hands into the box, which presented a risk of injury from sharps in the box and the risk of cross infection. In the orange area of AMU, we saw staff did not follow the trust infection control policies as sharps' bin that was three quarters full had not been sealed to prevent further sharp items being added to it. On CDU, we saw a sharps box that was full and not sealed and in an area that was accessible to patients and visitors. There was an increased risk of staff injuring themselves as sharps were not managed safely and in line with the trust's policy.
- The trust completed weekly audits of the cleanliness and infection control practices on the wards. The audits for all AMU areas for August and September 2016 showed ongoing issues with dusty equipment across the unit, staff did not follow procedure to date and sign when sharps bins were assembled. However, improvements were noted with the cleanliness of commodes and macerators in the sluice and the availability of a variety of sized gloves and aprons.

Environment and equipment

- At the previous inspection of the service in March 2016, we identified the environment and equipment did not consistently protect the safety of patients on AMU.

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Staff did not comply with trust's policy and national guidelines and recommendations regarding checking and servicing of emergency equipment. They did not check the resuscitation equipment daily on AMU. Nursing staff expressed concerns there were insufficient cardiac monitors to enable safe monitoring of patients conditions throughout the AMU.

- At this inspection records provided by the trust showed faulty equipment was attended to promptly when reported to the maintenance team. However, on CDU all 14 cardiac monitors located at patient bedsides had labels detailing they were due for servicing in June 2016. There was no record to evidence they had been serviced at that time. This meant staff could not be assured cardiac monitoring equipment was working correctly and was safe to use. Senior staff we spoke with confirmed they were not assured the monitors had been serviced.
- In several areas we found emergency resuscitation equipment was not checked daily in line with the trust's policy. This may pose risks of emergency equipment not being ready for use. On CDU records showed staff had not completed daily checks of the resuscitation equipment on 14, 15, 16, 19, 23 and 26 September 2016. Staff had only completed partial checks of the equipment on 28 September. When we visited the ward on 30 September, staff had not completed a check of resuscitation equipment. When we looked at the equipment, we identified an item that expired on 30 September 2016, which staff had not identified during previous checks. When we brought this to the staffs' attention, they promptly replaced the item.
- On a trauma and orthopaedic ward where medical outliers were cared for we found cleaning fluids and other fluids hazardous to health not stored securely.
- In the lilac area of AMU, staff completed daily checks of the emergency equipment. However, when we looked at the equipment we found equipment that was broken and dusty.
- We found that an agency nurse on one of the AMU areas did not know where the resuscitation

equipment was located. This meant in the event of an emergency situation, there was a risk that there would be a delay in accessing essential emergency equipment.

Medicines

- At the previous inspection in February and March 2016 we identified medicines were not stored securely within AMU. Medicines in all areas of AMU were stored in open shelves that were accessible to unauthorised personal, despite senior staff knowing all medicines should be stored securely. Emergency medicines were stored at the bottom of the resuscitation trolley in a main corridor accessible by the public and had no tamper evidence mechanism on it. Staff did not follow medicines management process when discarding medicines, including intravenous fluids. We saw the box used to discard medicines contained used gloves, intravenous medicine lines and general rubbish mixed together instead of just medicines to return to pharmacy.
- Following the inspection the provider was required to submit a plan to the commission detailing the action they were taking to ensure medicines were managed in a safe and secure manner. This included reinforcing to staff their accountability towards safe management and storage of medicines, audits of present practice and development of action plans.
- At this inspection, we found medicine management did not protect patients' wellbeing Medicines reconciliation did not always happen in a timely manner. The aim of medicines reconciliation on admission is to ensure that medicines prescribed on admission correspond to those that the patient was taking before admission. The National Institute of Clinical Excellence (NICE) medicines reconciliation adults' hospital guidance dated 1 December 2007 details, "Pharmacists are involved in medicines reconciliation as soon as possible after admission". Review of patients' records on CDU and AMU showed timeliness for medicines reconciliation varied and for one patient occurred three days after admission.
- Following the inspection, the trust provided copies of medicines' reconciliation audits carried out on the medical wards for July, August and September 2016. The audits showed 100% compliance with recording

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patient allergies on prescription charts. However only 76%-77% of patients had medicines reconciliation completed within 24 hours of admission. Overall 98% of patients admitted to the medical wards had a medicines' reconciliation completed at some stage during their admission. However, the records demonstrated that patients admitted to the medical wards at the weekend were less likely to have medicines' reconciliation completed within 24 hours of admission.

- We found staff did not consistently follow the trust's policies and procedures and Nursing and Midwifery Council (NMC) standards for the safe administration of medicines. For one patient on CDU and one patient on AMU, we found there were gaps on the medicines administration charts for patients who were prescribed Insulin. There was no reference on the chart to indicate any reason why the staff had not administered the insulin. Staff we spoke with could not confirm if these patients had received their prescribed medicines. On AMU and other medical wards, we saw patients medicines' administration charts were not consistently signed, dated or had a record of patients' allergies. Failure of nurses to sign medicine administration charts meant staff could not be assured that patients received pain relieving medicines or antibiotic treatment as prescribed. We observed on two occasions, in AMU, nursing staff administering medicines to patients without checking the patient's identification.
- On CDU we found one patient did not have a medicines' administration chart and staff did not know where it was. We observed staff took no action to locate the missing chart. This meant there was a risk the patient was missing administration of essential medicines.
- Since the last inspection, the trust had sought advice about the storage and accessibility of emergency medicines. Tamper evident emergency medicine boxes were stored on resuscitation trolleys. This practice met the guidelines of the Resuscitation Council (UK).
- We found boxes in the corridors of lilac and orange areas of AMU were still accessible to the general public which the trust told us were for the disposal of empty medicine containers. However, we saw they contained

used intravenous infusion bags, of which some were not empty. This meant there was a risk that intravenous fluids that contained medicines were accessible to the general public. We also saw the boxes were used for the disposal of general rubbish, rather than staff using the rubbish bins.

- Records showed that staff did not consistently record the medicines' fridge temperatures in AMU daily and in line with their policy. Records showed that for one day in August and six days in September there were no temperature recorded. Although the recorded maximum temperature was consistently out of range, there was no record to show staff had taken action to address the raised fridge temperature. This meant staff could not be assured patients were receiving medicines that were fully effective as they were not stored at the manufacturer's recommended temperatures.
- Data provided by the trust showed the AMU matrons were auditing staff compliance with checking the temperatures of medicines' fridges. The matrons had identified for the months of June, July and August 2016 there had been only one occasion when staff did not record medicine fridge temperatures.. However, the data did not indicate whether the range for minimum and maximum temperature was considered in the audit.
- We attended an internal accreditation meeting for AMU, in which two senior nursing staff presented data about improvements made in AMU and the changes that were still needed. One area identified that required improvement was the management of medicines in that they stated there were still a number of medicine errors being reported. There was no discussion about the action that needed to be taken to address these issues.
- General storage of patients' medicines had improved. We saw medicines were mostly stored in locked cupboards or lockers next to patients' beds.

Records

- At the previous inspection in February and March 2016, we identified patients records were not stored securely throughout AMU and medical wards we visited at that time. On AMU, notes were routinely stored in open shelves in the central ward areas. In

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other areas, we also saw notes left in a public corridor and outside consulting rooms where clinics were being held. On the wards, staff stored notes in open and unlockable notes trolleys. In all situations there was risk that unauthorised person could access the notes.

- The trust provided an action plan following the last inspection detailing the action they were taking to improve the quality and security of patient records.
- At this inspection, we found staff stored notes in trolleys that were shut and could be locked to ensure patients records were secure and could not be accessed by unauthorised personnel.
- However, we found in some areas of the hospital, the management of patients personal details and records did not ensure confidentiality of patients' information. On a trauma and orthopaedic ward, patients' details were displayed on a white board that was in full view of visitors. The white board had personal information such as details of patients who were nil by mouth, were due to have procedures such as removal of sutures, CT scans and intravenous antibiotics. The trust told us there was a consent process for patients to agree use of their information on white boards this way. However, when we reviewed patient notes, we saw no evidence that staff obtained consent from patients to enable their personal information to be displayed for anybody to view. In the orange area of AMU, a double computer screen was left open, with no staff in attendance, which would allow unauthorised personnel to view patient details.
- We reviewed the matron's audits of patient records on AMU for July, August and September 2016. These showed improvements in ensuring details such as patients name, hospital number, date of birth and the name of the ward were always detailed. However, the audits showed ongoing concerns with completion of ongoing assessments, documentation of changes in patient's care and conditions, evaluation and reviews of patient care, evidence of patient's involvement and acceptance of care and lack of discharge planning.
- We reviewed a sample of patients' documents across all medical areas we inspected. These showed that although risk assessments were completed, such as risks for falls, pressure injuries and malnutrition, there

was not always a plan developed for staff to follow to mitigate the identified risks. Where plans were in place, there was not always a review date to alert staff to review whether the care provided was effective.

- We found some patients' records across the medical services, where handwriting was illegible or difficult to read. We checked some records with the staff and they also confirmed that some records were not legible. This could pose risks of information relating to care and treatment being misunderstood and affecting patients' care.

Safeguarding

- The trust had safeguarding policies and procedures and staff told us this was available on the trust's intranet.
- Staff demonstrated a good understanding about safeguarding procedures. They were able to tell us what constituted abuse and the steps they would take if they identified safeguarding concerns and the process for reporting these.

Mandatory training

- During the inspection many staff across a range of wards told us, because of the busy clinical workload, they had no time to complete mandatory training.
- The trust provided data for mandatory training across the medical clinical services that included all medical wards, but not AMU. The trust's target for compliance with mandatory training was 85%. The data showed that medical staff consistently scored under 85%, with the exception of the diabetes and endocrinology directorate medical staff in March, April and June. Nursing staff achieved the trust target of 85% with the exception of nursing staff working in the cardiology directorate, the general medicines' directorate and the neurology directorate.
- Administrative staff consistently failed to meet the trust target with the exception of those working in the cardiology directorate, the gastroenterology directorate and the general medicine directorate. Allied health professionals met the trust's target with the exception of those working in the medicines central directorate. For the period March to August

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2016, over all medical staff had a compliance rate of 55% to 84%, nursing staff 50% to 92%, administration staff 27% to 96% and allied health care professionals 69% to 100.

- However, data provided by the trust following the inspection showed that for the period March to September 2016 there was only one month, August 2016, when staff across the emergency clinical service centre, which included AMU, and the medicine clinical service centre, met the trusts target for essential skills (mandatory) training. Overall, the trust almost met their target of 85% compliance with mandatory training for staff working in the AMU and with the urgent medical pathway.

Assessing and responding to patient risk

- At the previous inspection in February and March 2016, we found for some patients on AMU staff did not have appropriate care plans to meet identified risks and to ensure care was provided in consistent and safe manner. In AMU, staff did not always follow the electronic early warning system (EWS) process. This consists of a scoring system that helps to detect deterioration in a patient's condition.
- Following the inspection the trust was required to submit a plan to CQC detailing the action they were taking to address these issues. The action plan included a review of the current documentation audit tool, recording of risk assessments and documentation of risks, improve completion and quality of nursing assessment documentation, including falls and tissue viability risk assessments with appropriate individualised care planning and focussed education of staff. They told CQC that sustained improvement would be demonstrated through audit processes.
- At this inspection, we found patient EWS were reviewed at board rounds on AMU. Medical consultants told junior doctors what they needed to do in response to patients EWS scores. Review of patients' records showed generally EWS were carried out and documented and escalated to medical staff according the protocol and guidance.
- Review of 33 patient records showed staff completed assessments of risks to patients. However, care plans were not developed to address identified risk, these

were not always reviewed to record any changing needs and some did not include dates for review. This posed risks of patients not receiving consistent care and according to their assessed needs. Of the 33 records we reviewed across AMU and the medical wards, we found nearly half of them, a total of 15, did not have completed care plans.

- Examples included, for one patient on the winter pressures (E4) ward there was no documented evidence that staff had carried out a VTE (venous thrombus embolism) risk assessment and there was no direction to staff to look at the electronic records for one patient. Despite no VTE assessment having been completed, the patient was prescribed and administered medicines to reduce the risk of VTE occurring without a clear rationale for this action. This patient had a number of wounds, but there was no detail in their care plans about how staff should monitor the condition and manage the wounds to promote healing and reduce risk of further damage.
- Another patient, on the winter pressures (E4) ward who was immobile, had a pressure-relieving mattress on their bed. However, they were sat in a chair with no pressure relieving equipment for 3 hours. We reviewed their records, which showed nurses had not carried out an assessment of this patient's risk of developing pressure ulcers. This meant care to reduce risk of pressure ulcer development was not planned and there was no assurance the pressure relieving mattress was appropriate for the needs of the patient.
- A patient on CDU who had diabetes did not have a care plan that addressed the management of their diabetes. The nutritional care plan included actions such as "offer a variety of food choices." However, it did not detail the action required to ensure the patient's diabetes was controlled or the actions staff needed to take if the patient's blood sugar readings were outside the normal range. For a patient with known epilepsy, there was no care plan to inform staff about what actions they needed to take to reduce risk of harm to the patient in the event of them having a seizure.
- On AMU the care plan for a patient detained under the Mental Health Act did not provide any guidance for staff about the action they needed to take if the patient tried to leave the hospital. For a second

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patient on AMU, who was very anxious about their prognosis, their care plan simply said "provide reassurance". There was no guidance to staff about how to provide individualised support to the patient to relieve their anxieties.

Nursing staffing

- At the previous inspection in February and March 2016, we found staff rotas were planned with sufficient numbers of nursing staff to provide care for patients in AMU. However, at that time, staff told us because they may not work consecutive days in the same unit, this may affect the continuity of care for some patients.
- Data submitted by the trust to the National Quality Board showed that staffing levels in AMU during the period July to October 2016 consistently met or exceeded the planned staffing levels. At the inspection, we found the planned nurse staffing levels were met with the use of agency and bank nursing staff. However, we found in some areas this was having a negative impact on the care received by patients. The induction process for agency staff was not robust and what information was available to these staff was variable. In some areas, there was a folder for the staff to read, which staff said did not happen, as there was no time to do so. In pink unit, an agency staff member told us they had received an induction to the area they were working in. We asked this staff member to locate the emergency resuscitation trolley that they thought was located on the ward but could not find it. The emergency trolley was kept in the corridor a short distance from the ward. This raised concerns about patients' safety. The same agency nurse was not aware of what type of ward they were working on. They told us they were working in the discharge lounge. However, they were working on the AMU.
- Data provided by the trust showed there were 116 whole time equivalent (WTE) nursing vacancies across the medical wards.
- Agency staff predominantly staffed the winter pressures ward (E4). Data provided by the trust showed the planned nursing establishment for the ward was 13 WTE registered nurses and 15 WTE health care assistants. However at the time of the inspection there were only nine registered nurses and four health care assistants employed to work on that ward. The

trust told us agency nurses, who often worked there regularly, filled the vacant shifts. Feedback we received from staff and the duty roster seen indicated high reliance on agency staff who were not familiar with the ward. This affected continuity of care and patients were often not being washed or being assisted to get out of bed until lunchtime.

- There was no physiotherapist assigned to the ward and patients received minimal physiotherapy input. Staff told us this had a negative impact on the rehabilitation of patients and preparation for discharge.
- Although there was a standardised laminated poster to use in all clinical areas to display planned and actual staffing numbers, these were not visible at the time of our inspection in AMU or on the wards.
- We found staff did not incident report staffing shortages.

Medical staffing

- At the previous inspection in February and March 2016, we found there were insufficient numbers of speciality medical doctors to ensure all patients received timely reviews.
- Following the previous inspection, the trust introduced a new model for medical staffing in AMU. This meant there was an increase in consultant cover for AMU. There were two acute physicians working a long day, one acute physician working a short day and one geriatrician available, across AMU and ED for 12 hours. Acute physicians saw all patients during the 'day'.
- The medical teams on AMU were split into two teams who had responsibility for patients in different areas of AMU. The trust had introduced medical technicians in AMU who could complete routine tasks such as taking blood and doing ECGs, to release junior doctors to attend to patients.
- However, we found there were still concerns about the number of medical staff available to attend to patients. Staff expressed there was inadequate medical cover in AMU. They told us that to address the shortage of junior doctors, (at the time of the inspection, there were 115 junior doctor vacancies across the whole trust), the trust was now

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redistributing these vacancies across the whole trust. This meant there was not one area that had large number of vacancies while another was fully staffed. They expressed this practice was not working effectively because of increased levels of sick leave taken by the junior medical staff.

- We reviewed the junior medical rota for AMU. This showed the planned numbers on duty were six during the day and three at night. In July 2016, there were five day shifts when there were only five junior doctors on duty, and three shifts at night there only two on duty. In August 2016, there had been one day shift where there were only three junior doctors on duty, four day shifts when there were only five on duty and three night shifts when there were only two junior doctors on duty. In September 2016, there were three day shifts where there were only five junior doctors on duty, with all night shifts being fully staffed. The September data indicated junior medical staff levels in AMU were slowly improving.
- The pink area of AMU was used as an escalation area when there were no available beds in the hospital. Staff told us this area was nearly always open and seen as part of AMU. A member of the medical staff who worked on AMU told us the escalation beds in 'pink' did not always have a doctor allocated. Medical staff working in other areas of AMU picked up work in the pink escalation area. This conflicted with the information the trust provided us, which was that a dedicated 'take team' of medical staff were responsible for the medical care of patients' in the pink escalation area of AMU. There was no allocated junior doctor to E4. In both areas, a lack of dedicated medical staff increased the risk that patients would not be attended to in a timely manner by medical staff.
- We were told by the head of nursing and chief of services for AMU that there was no overlap of junior doctor shifts to promote effective handover to the oncoming team of medical staff. However, we did observe a 15 minute handover period between the night and day team of doctors, including junior doctors.

Major incident awareness and training

- At the previous inspection in February and March 2016, we found plans had not been developed to ensure patients were discharged in a timely manner to ensure availability of beds in the hospital and treatment space in ED.
- At this inspection, we found individual clinical areas were in the process of developing business continuity plans were in the relevant to their area. We viewed the draft versions of some these. They detailed actions staff should take in the event of staff shortages, lack of available beds and failure of essential equipment, such as loss of power, water and telecommunications.
- Staff were not aware of the business continuity plan for AMU; they said they would contact senior managers as needed.
- There were concerns about resilience of the urgent medical care pathway. At the time of our inspection all available escalation areas were open which meant there was limited capacity for further patients to be admitted, particularly if there was a major incident locally.

Are medical care services effective?

Requires improvement 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We rated effective as 'requires improvement' because;

- Staff did not consistently monitor effectiveness of pain relief.
- Lack of assessment and identification of patients who required assistance with eating and drinking meant they were at an increased risk of malnutrition. Failure to accurately monitor nutritional and fluid intake meant there was no assurance patients had sufficient intake to prevent malnutrition.
- The trust target of 85% of staff having an appraisal every 12 months was not met. There were no formal systems in place for staff to have regular supervision sessions.

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- Multidisciplinary working was not evident in all clinical areas. There was no physiotherapist or junior medical staff allocated to the winter pressures ward.
- Lack of some services at weekends had a negative impact on patients. Reduction of pharmacy services at the weekend had a negative effect on a timely completion of medicine reconciliation. Lack of physiotherapy services at weekends resulted in patients not being discharged at weekends.
- The planning and delivery of care was not always carried out in accordance with the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards (DoLS) and staff were not aware of their responsibilities under the Act.

However,

- Staff had access to guidance and information from the National Institute for Health and Care Excellence (NICE) and we saw these were usually followed.
- Medical staff reviewed all patients every day. There was a geriatrician on duty between 8am to 8pm seven days a week and an AMU consultant on duty 8am to 6pm seven days a week. An on call geriatrician or physician was available twenty four hours a day, seven days a week.
- All clinical staff had access to patients' records.
- There was access to a mental health liaison team for patients who required specialist mental health support to meet their needs.

Evidence-based care and treatment

- At the previous inspection in February and March 2016 there were no significant concerns identified with regard to patients receiving evidence-based care and treatment.
- At this inspection, we saw National Institute for Health and Care Excellence (NICE) guidelines information was available for staff to refer to. This included information about assessment and management of pressure ulcers and care of patients with diabetes. However, records we viewed did not demonstrate staff consistently put these guidelines into practice.
- The National Institute for Health and Care Excellence (NICE, 2010) recommends that all patients should be

assessed for the risk of developing thrombosis (blood clots) on a regular basis. Patients' records showed most were assessed on admission for their risks venous thromboembolism (VTE) in line with clinical guideline [CG92]. Depending on the level of risks, patients were prescribed treatment for the prevention of blood clots.

- The trust undertook audits of documentation and use of clinical guidelines. The audits for June, July and August 2016, showed slow improvements with documentation in line with national guidelines. However, there was no specific action plan to address issues where documentation did not meet national guidelines, such as evaluation of care and records being timed as well as dated and signed. Staff only received training at induction and had the support of practice educators. One senior member of staff on AMU told us they did not receive any feedback from documentation audits, so they were not able to support staff to make the changes required to ensure documentation met national standards. However, the trust told us a meeting had taken place on 27th September 2016 with a group of senior nurses from AMU to feedback the results of documentation audit and ask the group to plan next steps to bring about the required improvements.

Pain relief

- Nursing staff assessed patients' level of pain using a numerical scale and recorded this on the patients' Early Warning Score (EWS) chart. Records we reviewed were not consistent, as staff did not always record the outcome of assessments, pain control and its effectiveness.
- In one clinical area we identified a patient was in pain. Their record showed regular pain relieving medicines had been omitted and documented as not needed. Their pain scores were recorded as rising according to their EWS. However, staff had not taken appropriate action as no pain relief was administered. We raised this issue with staff at the time. However, when we returned to the clinical area we found staff had still not provided any pain relieving medicine to the patient and the patient was still experiencing pain.

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- There was no specific tool used to assess patients who were unable to verbalise their pain and this posed risks these patients may not receive adequate pain control.
- Patients we spoke with said they received adequate and regular pain control when they requested them.

Nutrition and hydration

- At the previous inspection in February and March 2016, we found assessments for the risk malnutrition were not consistently completed in AMU. This meant patients at risk of malnutrition were at risk of not being identified and therefore not receiving the appropriate treatment, care and support.
- At this inspection we observed staff used the Malnutrition Universal Screening Tool (MUST) to assess patients' risk of malnutrition. This was used at initial assessment of a person admitted to AMU. This was in line with the NICE clinical guideline 32 'Nutrition support in adults: oral nutrition support, enteral tube feeding and parenteral nutrition'.
- Patients on AMU who had dementia and required practical assistance to eat were not provided appropriate support. Their assessments did not identify they needed support at meal times. The hospital had a process where patients who required assistance or supervision at meal times were provided their meals on red trays. As these patients had not been assessed as requiring assistance, their meals were not provided on red trays and there were no visual clues for staff to identify patients who needed assistance.
- There was no consideration for example for people living with dementia who may have benefitted from finger food. Again, as assessments of patient's dietary needs were not thorough, this affected the type of food and support they needed. There were no adapted cutlery or plate guards to support and encourage patients to eat independently. The failure to assess and provide appropriate support for patients meant there was an increased risk of malnutrition.
- On another ward, we observed a staff member standing up whilst assisting a patient. There was poor interaction with the patient, no encouragement was given and we found staff feeding patient their dessert before their main meal. The record for this person showed they were confused and living with dementia. We raised our concerns with the nurse in charge.
- We noted that all courses of meals were served at the same time, which included hot desserts. This did not consider the needs of patients who may have been confused and presented with a number of dishes at the same time. A patient in AMU raised their concerns with the inspection team as their hot meal was served whilst they were away in the toilet. They were unhappy as the meal was cold. At the time of the inspection, staff told us there was no facility to keep the meal warm. Following the inspection we were advised by the trust that there was a heated trolley available which staff could use during a specific time to keep meals warm if patients were away from their beds when food was served.
- Staff also raised concerns of plans for patients in AMU to have a packed lunch such as sandwiches and removing the hot meal provision. This would affect patients as some of the patients may stay in AMU for a number of days. We raised this with lead for AMU who assured us this would not happen.
- Across all medical wards where medical outliers were cared for and AMU there was lack of consistency of recording food and fluid intake of patients who required this monitoring. This meant there was lack of assurance that patients were receiving sufficient fluid and nutritional intake to reduce risk of malnutrition. An example included for one patient their food chart detailed that for 27 September they had only had a meal in the evening. For 28 September, they had eaten no food. For 29 September, they had eaten half a bowl of porridge and had a fruit cocktail and for 30 September at 12.30pm there was no dietary intake recorded. We raised our concerns with senior staff at the time of the inspection.

Patient outcomes

- We have not reported on the trust's participation in national audits and performance, as we did not inspect all the specialities in medicine.

Competent staff

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- At the previous inspection in February and March 2016, it was identified that at times staff on wards and units where medical outliers were cared for, nursing staff felt they did not have relevant skills and knowledge to provide effective care.
- At this inspection staff working in areas that accommodated medical outliers remained concerned they did not have the appropriate specialist skills and experience to provide effective care for these groups of patients.
- Nursing staff told us appraisals were overdue because there was insufficient time to carry them out. This was confirmed in conversations with nurse managers, who told us they were struggling to achieve the trust target of 85% compliance with all staff having an annual appraisal. Appraisal rates for staff on AMU failed to meet the trust's target for June, July and August 2016, (75% to 77%).
- Data provide by the trust following the inspection showed that for the period March to September 2016 neither the emergency clinical services centre(which included AMU) or the medicine clinical service centre met the trust's target for all staff having an annual appraisal.
- There were no formal systems in place for staff to have regular supervision sessions with their line managers. Staff told us they would ask for help if needed but there was no system to monitor staff's practices. However, the trust told us all staff have a named team leader who was responsible for supporting them both professionally and pastorally and who was responsible for co-ordinating an annual appraisal.

Multidisciplinary working

- Multidisciplinary working was not consistent in AMU and some of the medical wards. Observation of the board meeting on AMU on 30 September 2016, showed the presence of senior nursing staff. However, there was no involvement of therapy staff in this meeting. Staff reported that the model of working in an AMU was medical led, rather than a multidisciplinary team approach.
- Staff on the wards and in AMU had access to allied health professionals that were employed by the trust such as example physiotherapists, occupational therapists, dieticians and neuropsychologists. Staff

described a joined-up team approach to assessing the diverse needs of patients and said they worked in a collaborative way. On the medical wards' staff confirmed patients had access to and were referred for psychological support as needed although there was a waiting list. A doctor in AMU confirmed that patients would be referred to the mental health team whilst they are in the emergency department prior to admission to AMU.

- However, during the inspection, we did not see any therapy staff on AMU. We did not see any evidence of involvement of therapists in the patients' records we reviewed, although staff said they would be available if needed. On the winter pressures ward (E4) lack of dedicated physiotherapist and junior doctor hampered multidisciplinary working. In AMU, nursing staff and junior medical staff told us it was easy to contact a consultant if they needed advice. The consultant had overall responsibility for a patient's care.
- Staff knew how to access the mental health liaison team for patients who required specialised mental health care input to meet their needs.

Seven-day services

- Staff reported there was usually good medical cover for AMU at weekends.
- Wards that accommodated outliers reported medical staff reviewed patients every weekday and records evidenced this. However, staff reported that access to medical staff to review medical outlier patients was difficult at weekends. This had the potential to delay decision making processes and treatments for patients accommodated on these wards.
- There was a geriatrician on duty between 8am to 8pm seven days a week and an AMU consultant on duty 8am to 6pm seven days a week. An on call geriatrician or physician was available twenty-four hours a day, seven days a week.
- Pharmacy services were provided Monday to Friday 9am-5pm and some cover over the weekend. There was an on call rota where pharmacy support was

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available. Lack of pharmacy cover at weekends had a negative effect on timely completion of medicine reconciliation for patients admitted during the weekend.

- Data provided by the trust showed there were no physiotherapists rostered to work on AMU at the weekends for the months of July, August and September 2016 with the exception of one physiotherapist on duty for one Saturday in August and one on duty for one Saturday in September. Physiotherapy cover was available on the general medical wards at the weekend, varying from one to three physiotherapists on duty. Staff confirmed that this affected patients' discharges as generally patients were not discharged at the weekend.
- There was a minimal occupational therapy service available across all medical wards at the weekend. Numbers of occupational therapy staff on duty ranged from nil to three on Saturdays and none on duty on Sundays.

Access to information

- Clinical staff had access to patients' records.
- Nursing staff told us when transferring patients between wards or teams, they received a handover of the patient's medical condition and on-going care information was shared.
- Patients' information was paper based and some were held on the trust's electronic system. These included patients assessments kept on hand held devices, which was password, protected.
- There was also an electronic records system where all professionals could add information, for example social care staff, nurses and allied healthcare professionals. Staff told us this was helpful, as it meant they could see the input of social services and did not need to spend time trying to contact social services to find out what actions they were taking.
- Staff had access to policies and guidance on the trust's intranet and as paper copies held in their clinical areas.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff's knowledge in relation to mental capacity assessment and deprivation of liberty safeguards (DoLS) was variable and staff were unsure of their responsibility about completing mental capacity assessments and DoLS applications.
- The trust's Deprivation of Liberty Safeguards: Practice and Procedures Policy dated 12 February 2016 states that "Assessing mental capacity and making decisions for those unable to do so for themselves is an interdisciplinary and/or multidisciplinary issue. Therefore, this policy applies to all permanent, locum, agency and bank staff of Portsmouth Hospitals NHS Trust and the MDHU (Portsmouth), including doctors, nurses, allied health professionals, support staff, social care professionals and managers." However, nurses told us it was the responsibility of medical staff to carry out mental capacity assessments and that nurses had no involvement in this process. This view demonstrated a lack of understanding of their responsibilities towards the mental capacity act. They were unclear whose responsibility it was to ensure care practices did not affect patients' liberty.
- We found practices that indicated the trust was not applying the Mental Capacity Act 2005 to care practices. A patient record showed they had a Deprivation of Liberty Safeguard (DoLS) in place, However, staff had not followed the process including best interests and there was no record of an application had been submitted to the authorising body. Other information such as the reason for the DoLS, timeframe and action plan to support the patient and review were not in place. A junior doctor told us they did not know about DoLS as the consultant would authorise this.

Are medical care services caring?

Requires improvement 

By caring, we mean that staff involve and treat people with compassion, kindness, dignity, and respect.

We rated caring as 'requires improvement' because;

- Patient's privacy and dignity were not always protected.

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- Patients and their representatives were not always involved in planning and making decisions about their care and treatment.
- In some clinical areas, the high use of agency staff who did not know patients very well, meant there was a lack of interaction between staff and patients in which to provide emotional support.

However,

- Patients on AMU praised staff for their care and compassion.
- There were examples of staff providing empathetic and emotional support to patients.

Compassionate care

- We found practices and culture that did not fully demonstrate compassionate care was always provided to patients
- Handover practices on the cardiac day unit did not protect privacy of and confidentiality of patients' information. The handover took place at the nurses' desk in front of patient's beds. Discussion about patients occurred less than three metres away from their bed spaces. Patients were not involved in the discussion. There was potential risk that patients would overhear discussion about other patient's conditions and treatments.
- On a trauma and orthopaedic ward where medical outlier patients were accommodated we observed two members of the nursing staff disregard a patient who was distressed and calling out for assistance to go to the toilet. A third nurse demonstrated an empathetic and caring response to the patient. They sat with the patient and explained in words the patient could understand that they "had a tube" to take the urine away. The nurse remained with the patient and repeated the information to help that patient understand.
- On the same ward, we observed a member of staff was standing over a patient assisting them with their meal, rather than sitting beside the patient.
- On CDU and trauma and orthopaedic ward (where medical outliers were accommodated) the inspection

team had to ask members of staff to provide privacy blankets for a number of patients whose lower half of their body was not covered and incontinence pads were visible hanging between their legs.

- On some areas of AMU, we observed discussion between staff referred to patients as bed numbers rather than their names. This showed a lack of respect for people they were caring for.
- However, patients we spoke with on AMU praised the staff for their compassion and kindness. We heard comments such as, "the staff are marvellous, I can't fault any of them. If I have asked for help they have been there to help and the doctors are really lovely", "everyone has been so kind, nothing is too much trouble", and "everything I have wanted doing has been done, the staff are brilliant".
- AMU took part in the Friends and Family Test (FFT). The Friends and Family Test is an important feedback tool that asks people if they would recommend the services they have used. The FFT results for AMU were included in the emergency medicine clinical services centre. The trust told us FFT results were displayed in the AMU corridor. However, we did not view them during this inspection.

Understanding and involvement of patients and those close to them

- At the previous inspection in February and March 2016, we found most patients felt they had enough information about their care. However, some patients on AMU said they had not been given information about the reasons for delays with their discharge from hospital.
- We found little evidence that patients and their representatives were involved in planning and making decisions about their care and treatment. Three patients we had conversations with on AMU said they did not fully understand what was happening with them. Review of care plans across all medical areas showed there was a tick box to indicate patients and relatives were involved in the care planning, none of these were ticked and there was no other documentary evidence to indicate patients and their representatives were involved.

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- Four relatives told us they were given some information when requested about the care and treatment of their relatives, although they said it was difficult to get to speak with the medical staff.
- Results of matron audits of patient documents, for June, July and August 2016, across the medical services indicated the lack of evidence of involvement of patients and their representatives was identified. There was no action plan to address this issue. However, the audit results did show an improvement. Only 14% of patient records evidenced involvement of patients and their representatives in June 2016. This figure rose to 48% in August 2016.

Emotional support

- At the previous inspection in February and March 2016 there were no concerns identified with the emotional support patients received.
- At this inspection, we observed examples of staff providing emotional support to patients, for example, one patient told us his wife was in another hospital and staff ensured he was kept up to date with her condition and progress.
- In some areas we noted patients had limited opportunity to discuss any concerns or anxieties with staff. This was because there was little interaction from staff to patients. The large numbers of agency staff used, meant there were large numbers of staff who did not know the patients well enough to interact with them in an effective and supportive manner.

Are medical care services responsive?

Requires improvement



By responsive, we mean that services are organised so that they meet people's needs.

We rated responsive as 'requires improvement' because;

- Plans to deliver the urgent medical care pathway had yet to be fully established.
- Patient flow through the hospital was compromised. There was an increasing number of patients who experienced delayed discharges, all available escalation beds were open and there had been no

improvements in the number of patients experiencing bed moves during the night. Consultants and senior managers did not show drive and innovation to promote the access and flow of patients through the hospital.

- Mixed sex breaches that routinely occurred on the Cardiac Day Unit and Renal Day Unit were not considered as mixed sex breaches. Mixed sex breaches on these wards were not reported because staff did not recognise them as mixed sex breaches.
- Average length of stay on AMU was above the target of 24 hours
- The needs of patients living with dementia were not fully considered.

However,

- There was evidence that changes were made in response to patient concerns and complaints.

Service planning and delivery to meet the needs of local people

- At the previous inspection in February and March 2016, concerns were identified with the slow implementation of plans to improve the delivery of the urgent medical care pathway. New initiatives discussed at risk summit meetings in December 2015 and January 2016 had not yet been implemented. This included a new medical model for admission, a short stay model of care, a frailty intervention team and GP heralded admissions directly accessing AMU rather than the emergency department.
- Following the inspection the trust was required to submit a plan to CQC detailing the action they were taking to address these issues. They provided details about the new medical take process, where, to ensure all patients were seen by a physician. All patients admitted were seen by a general physician before being referred to a specialist physician if required. They told us, following Royal Colleges of Physicians (RCP) guidance, all patients admitted during the day would be seen by a consultant within eight hours and for those admitted during the night they would be seen by a consultant within 14 hours. The trust told us that when patients were seen by the consultant this would include an estimated date of discharge (EDD).

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- The trust told us that there would be an increase from 50% to 65% of patients admitted on a short stay pathway, which meant they would be discharged from hospital within 72 hours of admission. There was a target to discharge patients from AMU within 24 hours of their admission. This was not being met.
- At this inspection, the planned changes had not yet been embedded into practice. The short stay unit had been open for seven weeks. However, staff told us the unit was not meeting the 72 hours discharge target. Lack of clarity about when the 72 hours should be measured from (admission to ED, AMU or the short stay unit), lack of therapy staff at weekends and lack of permanent nursing staff were stated by staff as reasons the short stay unit was not meeting the 72 hour target. The ward manager held regular meetings with the consultant body in order to encourage their engagement with the short stay model of care.
- Other measures introduced to support the delivery of the service for emergency medical patients were not yet fully embedded. Staff told us there was a new process for GP heralded patients to be admitted directly to AMU. However, staff told us, the GP heralded beds were not always kept vacant for these patients, with medical staff from ED overriding the practice and admitting patients from ED into the beds. After our inspection the trust told us there were no dedicated beds for receiving GP heralded admissions in AMU.
- At the previous inspection patients were not consistently cared for in same sex accommodation in the escalation areas. Following the inspection the trust was required to submit a plan to CQC detailing the action they were taking to address these issues. The trust told us the duty matron completed a daily review of compliance with single sex requirements in escalation areas using a daily check list, escalation areas were to be reviewed which was going to include CCG and governors validation and a programme of education was being provided for senior ward leaders.
- At this inspection, we found mixed sex breaches were still occurring in escalation areas. Staff on the Cardiac Day Unit (CDU) told us senior management told them that they did not need to declare mixed sex breaches until 8pm as the unit was a day unit. This practice overlooked the fact medical patients were admitted there as inpatients. The Department of Health (DH) website details that mixed sex breaches occurred the moment a patient is admitted as an inpatient, "The breach occurs the moment the patient is placed in the mixed-sex accommodation" and that it was not acceptable to set a time limit before recording mixing as a breach of the standard e.g. 2hrs, 4hrs, 12 hrs. The DH guidance "Eliminating Mixed Sex Accommodation" dated November 2010 details, "Sleeping accommodation" included "areas where patients are admitted and cared for on beds or trolleys, even where they do not stay overnight. It therefore includes all admissions and assessment units (including clinical decision units), plus day surgery and endoscopy units. It does not include areas where patients have not been admitted, such as accident and emergency cubicles". This guidance meant that the environment of CDU meant that if there was a mix of male and female patients in CDU, whether day patients or inpatients, the hospital was committing mixed sex breaches. The trust was not recording these as mixed sex breaches and therefore there was no accurate oversight of the frequency of mixed sex breaches.
- In CDU screens were available for staff to use to separate male and female patients receiving care on the ward. When we visited the ward on 30 September 2016, we saw there were male and female patients on the ward. There were two screens which looked like they were supposed to be used to separate the male section of the ward from the female section. However, staff were not using the screens which meant male and female patients were receiving care in direct view of each other. Staff we spoke with knew they were not supposed to have men and women together, but said they always did. They told us they were supposed to use screens, but staff moved the screens because they got in the way of trolleys and delivering care and treatment to patients. One member of staff told us that they did not "know how they (the trust) got away with it".
- Staff told us that when they knew how many patients needed to stay in the unit overnight, bed moves across the hospital were arranged in order to create a single sex environment for patients overnight. This meant there was an increase in patient bed moves. However, this did not address the issue that patients were cared for in mixed sex accommodation during the daytime.

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- There was a similar situation on the renal day unit, where patients of the opposite sex shared sleeping accommodation and did not have access to segregated bathroom and toilet facilities.
- On the winter pressures ward the female shower was located opposite a bay accommodating male patients. This meant female patients had to walk past male patients to access showering facilities and was a mixed sex breach
- At the previous inspection we found that although there was one hand washing sink, there were no washing facilities on Pink Unit in AMU. Patients were required to walk down a public corridor to access showers and toilets. On this inspection we found the situation remained the same and patients were seen walking down the corridor to access showers and toilets.
- Following the last inspection the trust was required to provide CQC data about the number of delayed discharges, the number of medical outliers, the number of patients moving wards overnight and the number of escalation beds in use. The data for the period 27 March 2016 to 10 October 2016 showed an overall reduction in the number of medical outliers in the hospital. However, there was no clear reduction in the number of patient bed moves over night, there were increased numbers of escalation beds in use and an increase in the number of delayed discharges for patients who were medically fit.
- This data showed there was an overall downward trend in the number of medical outliers. For the week beginning 21 March 2016 there were a total of 211 medical outliers, for the week beginning 3 October 2016 there were a total of 168 medical outliers in the hospital.

Access and flow

- Average bed occupancy was 96.4%. This is higher than both the national average of 88% and the national guidance that bed occupancy should not be above 82%.
- At the previous inspection in February and March 2016, serious concerns were identified with the access and flow for medical admissions. There was no cohesive planning for patient flow through the hospital and bed availability. Patients were frequently moved from ward to ward, which affected the timeliness of discharge. Patients had multiple bed moves and were frequently moved at night when sleep should be encouraged.
- During the last inspection, there were delays in patients being discharged from the hospital, which affected the availability of beds for patients who needed to be admitted. Some patients had been identified as fit for discharge, but medical and nursing staff had not taken any further steps to discharge the patients.
- Following the inspection the trust was required to submit a plan to CQC detailing the action they were taking to address these issues. The trust told us how they were making improvements to patient discharge processes and thus the patient flow in the hospital.
- The same data showed escalation bed usage was higher during the four weeks between 12 September and 10 October (948 beds) than during the earlier four week period between 21 March and 18 April (723 beds). This represented a 31% increase. The first week of October saw 265 escalation beds used, the highest number in any week during the three periods analysed. Usage was lower between 30 May and 3 July.
- For the period September to October, there were a total of 1256 patients moved to a different ward overnight, ranging from 26 to 65 patients moved overnight. The data showed there was no clear overall trend in the number of patient bed moves over night between March and October 2016, with number of bed moves ranging from 382 to 293 per week. It is nationally acknowledged this has a high impact on patient's wellbeing causing them distress by being cared in unfamiliar environment and with unfamiliar nursing staff. The British Medical Association also highlights that patients are at increased risk of infection and that it is unlikely that patients will eventually end up in the right ward or place of care if they move wards overnight.
- Review of four patient's records on E4 ward, showed some patients experienced multiple bed moves during their admission to the hospital.

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- For the period, March to October 2016 there was an upward trend of delayed discharges for patients who were medically fit. This included patients whose discharges were delayed for 24 hours, for one to two days and those delayed over seven days. For the week beginning 21 March 2016, there were 212 delayed discharges over seven days, for the week beginning 3 October 2016 this number was 902.
- The trust recorded reasons for delayed discharges. However, the records did not detail reasons for all delayed discharges and for some reasons it was not clear whether they were due to external or internal external reasons. Data provided by the trust showed a significant number of delayed discharges were due to an "unspecified reason." This meant it made it difficult for the trust to identify areas of the discharge process that needed improving. Physiotherapy or occupational therapy were reasons detailed for some delayed discharges. It was not evident whether this related to hospital based therapy or community based therapy service. Other reasons for delayed discharges included external factors such as waiting for care home beds or a package of care in their own homes and hospital processes and decisions, such as decisions from senior clinicians or the patient required further interventions.
- Staff told us the average length of stay for patients in AMU should be 24 hours. However, some patients stayed longer and an average of three to five days. This included patients who were moved to different areas in AMU such as pink ward where they accommodated short stay patients.
- However, data provided by the trust showed for July, August and September the average length of stay was consistently above 24 hours ranging from 25.5 hours to 27.5 hours
- Part of the plan to improve patient flow through the hospital was the introduction of the nationally recognised SAFER patient flow bundle. This is a combined set of simple rules for adult inpatient wards to improve patient flow and prevent unnecessary waiting for patients. Senior managers told us SAFER was being embedded with frontline staff at the time of our inspection. They acknowledged that SAFER was not in operation in all areas at that time.
- We observed an AMU board meeting on 30 September 2016. Consultant medical staff, junior doctors, senior nursing staff and other members of staff attended this. Consultant staff did identify potential discharge dates in line with SAFER but there was no discussion around what could be done to bring discharge dates forward. The junior doctors appeared to have an understanding of the need to facilitate discharges and on two occasions challenged the expected discharge dates. However, the meeting did not demonstrate urgency to relieve bed pressures.
- There were meetings on bed availability that were held three times a day, to determine priorities, capacity, and demand for all specialities. We observed an end of day bed management meeting. The meeting was chaired by the operations manager and attended by approximately 15 members of staff from a variety of backgrounds, including two duty managers and five senior nurses from different departments. The bed meeting supported efficient exchange of information but did not demonstrate any real innovation or motivation in moving patients through the hospital to create beds.
- The trust had opened a winter pressures (E4) ward. This ward was opened to accommodate patients medically fit for discharge, but their discharge was delayed due to various reasons. However, discussions with members of staff indicated the aims of the winter pressures ward were not being achieved. Lack of medical and therapy staff attached to the ward meant facilitating effective discharges was compromised. There was no discharge liaison member of staff taking responsibility and pushing for patient discharges.
- Review of four patient's records on E4 ward, showed patients experienced delays in discharge. One patient had waited over two months and another 16 days after assessed as medically fit for discharge. For two other patients delays in accessing allied health professionals indicated possible delays in their discharges. One patient admitted on 15 September 2016 with an estimated discharge date at that time of 4 October 2016 had only been referred to the occupational therapy team on 29 September 2016, five days prior to the planned discharge date. A second patient admitted on 16 September, was waiting for physiotherapy treatment. The ward had no allocated

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physiotherapist so access to physiotherapy services was compromised, which had potential to compromise timely treatments and effective discharge arrangements.

- When we inspected the cardiac day unit (CDU) on 30 September 2016, there were 10 medical patients who had stayed overnight in the unit. This meant six patients who were due to be admitted to CDU that day for cardiac procedures were postponed because there were no available beds. Staff told us this was not an uncommon experience. They told us on average they contacted patients three times a week to cancel their admissions and this generally affected three to four patients at a time. However, data provided by the trust indicated cancellations of admissions to CDU because of bed availability was not as frequent as indicated by staff. The trust detailed that between 4 July 2016 to 10 October 2016 CDU there were 55 cancellations for patients with planned admissions to CDU. Of these, 35 were for non-clinical reasons and only seven of them due to beds not being available for the patients.
- An integrated discharge service had commenced the week of the inspection. The objective of this team was to arrange equipment and services that patients needed for discharge before they were medically fit to be discharged, and thus reduce the number of delayed discharges. This service had yet to be embedded into the running of the hospital.
- Staff told us patient flow through the hospital was challenged by some speciality medical consultants struggling to adapt to the new model of working.
- At the previous inspection in February and March 2016, the provider did not use the discharge lounge to promote effective patient flow through the hospital. Since that inspection, the discharge lounge had a permanent location that accommodated both patients who needed to rest on a bed and those who could sit in chairs. Staff working in the discharge lounge in the morning, identified from hospital records patients who were due to be discharged that day. They supported the wards to discharge those patients in the morning by helping staff with the personal care of those patients, arranging delivery of medicines to take home and transferring the patient to the discharge lounge.

Meeting people's individual needs

- We saw evidence in patients records of lack of action taken by the hospital to refer patients to services to help with their individual needs. For example on CDU for a patient who had memory problems, their care plans detailed their GP needed to be asked to refer the patient to a memory clinic. There was no consideration of whether this patient, once home would manage to attend a memory clinic unaided, and there was no consideration by medical staff to directly refer the patient to a memory clinic.
- We observed the lunchtime meal service in AMU and E4 ward and found patients did not always receive individualised support with their meals. Some patients needed support to sit up in bed to enable them to eat, others were very low down and could not see their meals. We brought these to the staff's attention and patients were then assisted
- On AMU, patients did not always get the individualised support they needed at meal times. Lack of assessment and identification of patients who required assistance with eating and drinking meant assistance was not always provided. For example, we observed a patient served their lunch at midday; no member staff assisted the patient. The patient did not have their meal until a member of their family arrived at 12.15pm who helped them.
- The needs of patients living with dementia were not fully considered. There was no clinical pathway for patients who had delirium or were living with dementia. Staff completed electronic dementia assessments for patients. However, the assessments did not inform care planning. Across all wards, patients living with dementia did not have plans of care identifying the individual support and care they needed in respect of their dementia.
- However, in some areas action had been taken to meet the needs of patients living with dementia. In AMU, a trolley with memorabilia items was being developed to provide meaningful activity and distraction for patients living with dementia. Records and conversations with staff on AMU identified they had attended dementia study days.
- Further action the trust had taken to meet individual needs included purchasing coloured drinking glasses

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which enabled frail patients with visual or cognitive impairments to identify drinking glasses. We saw on one ward a patient living with dementia was supported to nurse a doll, which is a recognised practice that can provide meaningful activity for some people living with dementia and reduce anxiety.

Learning from complaints and concerns

- Information we received from patients and stakeholders before the inspection indicated the trust was not always responsive to complaints in an effective and timely manner. Patients told us they had to push to get resolution to their complaints and there was a lack of support for them when attending meetings about their complaint.
- However, there was evidence that AMU was responding to concerns and complaints. Changes made as a result of patients concerns and complaints included improved signage, introduction of analogue clocks and changes in staff name badges so patients could read them.
- AMU had identified a main theme of complaints from patients was regarding communication and understanding of what medical staff were telling them. To address this, a member of the nursing staff was now taking part in the ward round, to support patients with asking medical staff questions. It was not clear whether any action had been taken to address this issue with medical staff in respect of how they communicated information to patients.

Are medical care services well-led?

Inadequate



By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

We rated well led as 'inadequate because;

- Vision and strategy of the service had limited success in bringing about improvement of patient experiences.

- Governance processes were not effective at identifying risks and improving safety and quality of services provided.
- Leadership of AMU was medically led, nursing staff had little input into how the unit was managed and led.
- On CDU and the winter pressures ward, staff felt supported by local leadership, but not by the senior management. They did not feel listened to and said they were just left "to get on with things."
- Staff were demoralised by the impact the continued lack of improvement in the urgent medical pathway had on them and patients.
- Staff on wards and AMU felt disengaged with senior management.
- There were concerns about the sustainability of the urgent medical care pathway.
- Culture of the consultant body and the hospital did not support effective change and implementation of the short stay service.

However,

- There were localised innovations in AMU to meet patients' needs.
- The discharge lounge developed and implemented processes to support effective discharge and patient flow through the hospital.
- A plan was being followed by the manager and staff on the short stay ward to introduce and embed an effective short stay service for urgent medical patients.

Leadership of service

- At the previous inspection in February and March 2016, we found there was variable leadership in the urgent medical pathway services. At that time there was a clear local medical leadership on the AMU and senior nurse leadership on all the wards inspected. However, there was variable leadership from medical consultants throughout the trust, not all medical consultants engaged with the plans for future change. Senior hospital managers did not have oversight of the urgent medical pathway as a whole. At bed meetings, they did not work together to forward plan to ensure future availability of beds.

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- Following the previous inspection CQC also took enforcement action that required the trust to ensure there was effective leadership of the emergency care pathway. A clinical transformation lead was appointed based on external advice and agreement who had the authority to make decisions, and ensure there was swift and appropriate action in relation to identified problems and that there should be effective leadership, resource and support of the trust improvement plan to ensure changes were appropriately supported and implemented at pace.
 - At this inspection, we found that although leadership for urgent medical services had been strengthened, this had not yet resulted in significant improvements for patients admitted on the urgent medical pathway.
 - The leadership on AMU was medically led. This had been identified by the new transformation leader who was trying to promote change in the leadership and to empower nursing staff to share the leadership with medical staff.
 - The trust had introduced development programmes for band 7 nurses in AMU and on the medical wards. The programmes were planned to develop the leadership skills of band 7 nurses, improve safe and effective working practices and improve joint working between the nursing and medical teams.
 - On the winter pressures ward the senior sister was very aware of the issues and challenges facing the establishment of the ward but felt “helpless” to get things moving and felt they were working “against the tide.”
 - Staff on CDU felt unsupported by the senior management. They told us their senior nurse and immediate managers were supportive. However, they felt the senior managers did not listen to them, they felt they were just left “to get on with things”. Staff commented that they never saw senior managers.
 - On both days of the inspection, the escalation area (pink area) of AMU was open. The trust told us the nurse in charge was responsible for supporting all areas of AMU, including the pink escalation area. However, on both days of the inspection we observed staff in the pink escalation area of AMU received little support and guidance from the nurse in charge resulting in the appearance of a chaotic work area.
 - However, in some areas of the urgent medical pathway services local leadership was strong and proactive. This was demonstrated in the discharge lounge, where the leadership had developed a process that supported the wards to effectively discharge patients in a timely manner.
 - The ward manager on the short stay unit was proactively driving the implementation of the short stay model of care. They had regular meetings with the consultant body to encourage their engagement with the short stay model of care. However, they described the culture of the consultant body and the hospital as not supporting effective change.
- ## Vision and strategy for this service
- At the previous inspection it was identified senior managers had developed a strategy to improve the urgent medical pathway. However, at that time there were delays in the implementation of the strategy that meant the required improvements had not been made.
 - At this inspection, we found the improvement strategy was having limited success with improving the experience patients had when admitted following the urgent medical pathway process. Senior nurses working on the short stay ward told us the trust vision for the short stay unit lacked clarity and focus, which meant it was not working effectively. On CDU, staff told us they no longer had confidence the trust's strategies would bring about the improvements required in the urgent care pathway. They said the trust had continually told them the situation would get better, but they felt it had not. CDU still had to accommodate medical outlier patients.
 - Staff did not feel the urgent medical care pathway introduced to improve the service and experience for patients, was resulting in the intended improvements.
- ## Governance, risk management and quality measurement
- At the previous inspection in February and March 2016, it was identified quality measurement processes had not been developed to measure improvements in the urgent medical pathway. This meant the trust did not have a method to measure whether changes made to the service were bringing about

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improvements to the urgent medical pathway. Following the inspection the trust was required to submit a plan to CQC detailing the action they were taking to address these issues. CQC also took enforcement action to ensure the trust monitored the effectiveness of the changes made to the urgent care pathway. The trust was required to monitor daily and submit weekly reports to CQC about the number of medical outliers, number of escalation beds in use, the number of patient moves for non-clinical reasons including multiple moves, moves of vulnerable patients and moves over night, number of patients whose discharge was delayed and numbers and details about incidents reported on AMU. The trust complied with this enforcement action and provided CQC with weekly reports.

- At this inspection, we found governance processes were not effective at assessing or monitoring systems to improve the safety or quality of the services provided. Processes failed to identify mixed sex breaches and support effective patient access and flow through the hospital. Systems were not effective to enable improvements with timely patient discharges from hospital.
- We found the trust's risk management process were not effective at identifying risks to the service.
- The emergency medicine services and general medicine risk registers identified many of the risks to patient care and safety identified by CQC during the inspection. Risk registers detailed the action to be taken to mitigate risks, the time scale for action and review dates. Risks were reviewed and changes made to the level of risk as appropriate. However, there was little movement with the level of risk attributed to the identified risks, suggesting the action taken was not effective at reducing the level of risk.
- Some risks identified by CQC during the inspection were not detailed on the risk registers, indicating the trust had not identified all risks. This included the management and administration of medicines, adherence to infection control policies, cleanliness of equipment and up to date servicing and maintenance of equipment. As risks were not identified by the trust, there was a risk the trust would not take active action to mitigate risks and make necessary improvements.

- The trust had introduced accreditation processes, where clinical areas critically analysed their progress with meeting CQC fundamental standards and the needs of patients admitted to their clinical areas. We attended an accreditation meeting for AMU. This identified improvements in the unit and areas that needed further improvements.

Culture within the service

- At the previous inspection in February and March 2016 we found staff felt there was a disconnect between themselves and senior management. Some managers felt excluded from plans to develop and improve their service. Ward staff felt under pressure from senior managers to move patients who were not appropriate to be moved to alternative wards.
- At this inspection, we found staff that were demoralised working in all areas where medical patients were looked after. Staff told us they were "change fatigued."
- Staff felt, that since the last CQC inspection, changes had happened at senior management level, but had not filtered down to the clinical areas. The meant there was slow progress with making the required improvements.
- Staff on CDU described a demoralised work force, due to the number of outliers they had to look after. They described their core business should be day case procedures, but they were routinely providing general medical care to outliers. Trust leaders told them the outlier situation would get better but it did not, staff felt it was getting worse and this affected morale on the ward. One member staff told us they no longer enjoyed working there. Other staff told us morale was so low that staff wanted to leave. The team leader in one area of AMU told us they were not able to lead the team because staff, including them self, were routinely moved to other areas so there was no ability to develop and culture a team working ethos.
- Senior leaders told us culture in AMU was very difficult. They said the culture had been medically driven for too long, resulting in a lack of effective nurse leadership. Senior leaders told us 'nurses do as they are told' and there was no strong nurse leadership

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- Senior leaders, including nursing and medical leaders, told us they were aware there was a cultural problem with some of the medical consultants who were reluctant to embrace new ways of working. Despite being aware of the issues and the need to make improvements, discussions and observations during the inspection showed a reluctance by senior leaders and medical staff to take responsibility for implementing and making the required changes. One senior medical consultant told us that the various external advice given to the hospital was not followed through by the external advisors. There was no awareness by them that it was the trust's responsibility to follow and implement any advice given to them.
- However, practices such as coffee morning with matron were being introduced, to promote staff interaction and improve morale.

Public engagement

- Public engagement was not assessed during this focused inspection.

Staff engagement

- At the previous inspection in February and March 2016, we found the trust had not fully engaged with

staff with regard to changes being made in the urgent medical care pathway. This meant not all staff knew about the changes and therefore they were not effectively implemented.

- At this inspection we found staff still did not feel the trust was fully engaging with them about the changes required or were sought their views about how changes could be made effectively.

Innovation, improvement and sustainability

- At the previous inspection in February and March 2016, staff described an environment and approach to improvement and innovation that was lacking in grip and pace.
- At this inspection, we found staff were supported to make improvements and innovations in their work areas. In AMU, a nurse had developed a magnet to be displayed behind the patients' bed to alert staff the patient required mouth care. The same nurse had introduced coloured drinking glasses on the ward for patients who could not identify clear glasses easily.
- However, the present way of working was felt not to be sustainable by staff. During the inspection all the possible escalation areas in the hospital were open, which meant there was a risk the trust would not manage if the workload suddenly increased.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital **MUST** take to improve

The trust must ensure

- All incidents and near misses are reported using the trust's incident reporting processes.
- All staff follow the trust's infection prevention and control procedures.
- Staff follow the trust's medicines' management procedures.
- All equipment is maintained and is ready and safe to use.
- All emergency equipment is checked, following trust procedures, to ensure all equipment is present, in date and in working order.
- Patient details and information are not accessible to unauthorised personnel.
- All patients have an individualised care plan to enable staff provide the appropriate care and treatment.
- There is adequate medical cover at all times, including cover in escalation areas and the winter pressures ward.
- Completion of patient documents follows national guidelines, including accurate completion of food and fluid charts.
- Patients receive the assistance they need at meal times to reduce risks of malnutrition.
- Appraisal and supervision meets the trust's targets.
- Staffing at weekends does not have a detrimental effect on patients flow through the hospital and discharge planning.
- Staff are aware of their responsibilities towards the Mental Capacity Act 2005.
- Planning and delivery of care is in accordance with the Mental Capacity Act 2005.

- Needs of patients living with dementia are met.
- Mixed sex accommodation breaches are identified and reported and take action to reduce their occurrence.
- Patients and their representatives are involved in planning and making decisions about their care and treatment.

Action the hospital **SHOULD** take to improve

The trust should ensure:

- Mortality and morbidity meetings include learning from reviews of care and treatment.
- Safety thermometer information is displayed in all clinical areas.
- Planned and actual staffing levels are displayed in all clinical areas.
- Serious incidents are investigated in a detailed and comprehensive manner.
- There is sufficient flow of patients through the emergency department so that patients do not have to wait outside in ambulances.
- Ligature risk assessments are undertaken in all rooms that may be used by people with mental health problems
- Length of stay on AMU meets the trust target of less than 24 hours.
- Length of stay on the short stay ward meets the trust target of less than 72 hours.
- The urgent medical care pathway is fully established and embedded into the management of the hospital.
- There is an action plan for, and a demonstrable reduction in patients being moved overnight.

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

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

- Patients and their representatives were not always involved in planning and making decisions about their care and treatment.
- The needs of patients' living with dementia were not fully considered.

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

- Mixed sex accommodation breaches routinely occurred (and were not reported in line with national guidance) in the Cardiac Day Unit and the Renal Day Unit.
- Patients were left with their lower half of body exposed and revealing incontinence pads.

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

- Planning and delivery of care was not always carried out in accordance with the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards.
- Staff were not aware of their responsibilities under the Mental Capacity Act 2005.

This section is primarily information for the provider

Requirement notices

Regulated activity

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

- Staff did not always wear personal protective equipment when administering injections, carrying bedpans and making beds.
- Equipment was not clean.
- Sharps boxes were overfull.
- Nurses did not sign for medicines administered.
- Nurses did not always check the identity of patients' before administering the patients' medicines.
- Storage of emergency medicines in pink areas of AMU were not secure.
- Medicine fridge temperatures on AMU were not recorded daily and where recorded were consistently outside the recommended temperature range.
- Medicines reconciliation was not always carried out in a timely manner.
- Checks on emergency equipment were not completed in accordance with trust policy. When completed checks of emergency equipment did not identify broken or dirty equipment.
- Cardiac monitors on the cardiac day unit had not been serviced.
- Incidents and near misses were not always reported. Staff did not always receive feedback from incidents they reported.
- Staff did not meet the trusts target for completion of appraisals.
- Induction processes for agency staff were not robust.
- There was no medical staff allocated to the pink area of AMU or the winter pressures ward.
- Patients did not routinely have robust, individualised care plans to enable staff to plan and deliver their care and treatment appropriately and mitigate any identified risks.

This section is primarily information for the provider

Requirement notices

- Lack of assessment and identification of patients who required assistance with eating a drinking meant they were at risk of malnutrition.

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

- Governance processes were not effective at identifying risks and improving safety and quality of services.
- Improvements to patient flow through the hospital had not been achieved.
- Management of records did not always protect confidentiality of patient information.
- Handwriting in some patient records was not consistently legible.
- Patient records were not always signed or had the designation of the member of staff completing the record.

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

- Staff did not receive appraisal according to the targets set by the trust.
- Induction processes for agency staff was variable and not robust.
- Reduced numbers of therapy and pharmacy staff on duty at weekends had a negative effect on patient flow through the hospital.

This section is primarily information for the provider

Enforcement actions

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.