United Lincolnshire Hospitals NHS Trust

Pilgrim Hospital

Quality Report

Pilgrim Hospital
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Lincolnshire
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Date of inspection visit: 30 November 2018
Date of publication: 20/12/2018

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

Summary of findings

Letter from the Chief Inspector of Hospitals

United Lincolnshire Hospitals NHS Trust was formed in April 2000 by the merger of the three former acute hospital trusts in Lincolnshire, creating one of the largest trusts in the country. The trust serves a population of approximately 700,000 people, situated in the county of Lincolnshire.

We carried out an unannounced focused inspection of the emergency department at Pilgrim Hospital on 30 November 2018, in response to concerning information we had received in relation to care of patients in this department. At the time of our inspection the department was under adverse pressure.

We did not inspect any other core service or wards at this hospital or any other locations provided by United Lincolnshire Hospitals NHS Trust, however we did visit the admissions areas Integrated Assessment Centre (IAC) which included Ambulatory Emergency Care (AEC) and Acute Medical Short Stay Unit (AMSS) to discuss patient flow from the emergency department. During this inspection we inspected using our focussed inspection methodology. We did not cover all key lines of enquiry and we did not rate this service at this inspection.

Pilgrim Hospital, Boston is a large district general hospital located on the outskirts of Boston. At Pilgrim hospital the urgent and emergency services consists of the emergency department (ED),Integrated Assessment Centre (IAC) which included Ambulatory Emergency Care (AEC) and Acute Medical Short Stay Unit (AMSS). At the time of this visit the AMSS was operating 24 of the 48 beds in which it had allocated.

The ED has one triage room, 10 major cubicles, three minor cubicles, one ‘fit to sit’ room, a see and treat room, a plaster room, a clean procedure room, four resus bays, three rapid assessment and treatment (RAT) cubicles, one waiting room and a quiet relatives room (which was also used as a mental health assessment room). The department also has one children's cubicle.

Pilgrim Hospital emergency department supports the treatment of patients presenting with minor, major and traumatic injuries. Serious traumatic injury patients receive stabilisation therapy before transfer to the major trauma centre at a neighbouring NHS trust.

Our key findings were as follows:

- There were unsafe, unvalidated and unreliable systems in place to identify critically ill patients who may present to the department. The triage process was not effective in early detection of acutely unwell patients. Staff used a categorisation scale of one to five (one being immediate priority and five least priority). We saw patients such as a patient with a diabetic ketoacidosis (DKA) categorised as a category three when they should have been categorised as category one (immediate priority). We also saw a child with potential sepsis was also categorised as a category three when they should have been categorised as category one (immediate priority).
- We saw delays more than three hours for patients to be assessed by the medical team.
- We saw patients arriving by ambulance remained on the ambulance between 20-65 minutes waiting to enter the department. Whilst the patients remained under the care of the ambulance crew, there was no system in place to prioritise the patient who may have a high early warning score, indicating they may be sick.
- Whilst there was a “track and trigger” tool in place to monitor those patients who had been admitted to the department, staff did not always carry out observations in line with trust protocol and in a timely way. We saw critical observations go overdue for significant time periods. Patients who were at risk of deteriorating consciousness levels were not monitored effectively.
- There was no oversight of patients pre- and post-triage in the main waiting room and routine observations were not performed on these patients following triage.

Summary of findings

- Staff did not always commence interventions or treatment in a timely way. We saw a patient had waited two and a half hours following a senior review to be commenced on a diabetic ketoacidosis pathway, despite presenting to the department three hours and 42 minutes earlier.
- Patients were not always getting their medicines in a timely manner and when they needed them. Doctors did not always communicate effectively with nursing staff when they had created a plan, prescribed a treatment or wanted an intervention for a patient. We saw four patients who required medication administering,however, doctors had not alerted this to the nursing team.
- There was an unstructured approach to patient flow. All components of the patient flow system were not managed or escalated appropriately.
- The Rapid Assessment and Treatment (RAT) process was ineffective at reducing ambulance handover times. At the time of our inspection the average time patients were waiting for RAT was two hours and nine minutes. We saw many patients held on ambulances.
- Whilst beds had been identified for some patients, patients were not always moved from the ED in a timely manner.
- We saw there were significant issues in relation to patient flow which led to crowding and patients receiving care in corridors. Patients were experiencing unacceptable waits. Staff did not follow the escalation policy in use to ease and manage patient flow effectively.
- The nurse staffing levels and skill mix were not sufficient to meet the needs of patients. The department was under extreme pressure at the time of our inspection and we saw no action taken to assess nursing staffing levels were sufficient to meet the increasing capacity, demand or patient acuity issues.
- Children in the department were placed at risk of harm as they were not cared for by nursing staff with the necessary competencies to provide safe and effective care.
- Medical staffing was a mixture of junior, middle grade and registrar doctors, 80% of the medical workforce were locum. Despite the department being under extreme pressure at the time of our inspection we saw no action taken to assess medical staffing levels were sufficient to meet the increasing capacity, demand or patient acuity issues. We heard how some doctors had not had a break for the entire 12-hour shift.
- Leadership within the department was not effective. There was a lack of co-ordination between the consultant in charge, nurse in charge and site management team. The consultant in charge had no awareness of the increasing wait for senior review, rapid assessment and treatment area or ambulance handover delays.
- We found a culture of blaming overcrowding and low staffing levels / recruitment and use of agency staff for poor compliance with safety measures and poor practice. Nursing and medical staff used overcrowding as a rationale for lapses in care we identified during our unannounced inspection.
- The shift by shift management of risks, issues and performance in the Emergency Department (ED) was not robust. Our inspection team had to escalate several immediate patient safety concerns to medical and nursing staff to keep patients protected from avoidable harm. We also saw insufficient action to manage handover delays, overcrowding and poor staffing levels, this lead to poor patient experience.

Amanda Stanford

Deputy Chief Inspector of Hospitals (Central Region)

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services		We carried out an unannounced focused inspection of the emergency department in response to concerning information we had received in relation to care of patients in this department. At the time of our inspection the department was under adverse pressure. We did not inspect any other core service or wards at this hospital or any other locations provided by United Lincolnshire Hospitals NHS Trust, however we did visit the admissions areas Integrated Assessment Centre (IAC) which included Ambulatory Emergency Care (AEC) and Acute Medical Short Stay Unit (AMSS). During this inspection we inspected using our focussed inspection methodology, focusing on the concerns we had. We did not cover all key lines of enquiry. We did not rate this service at this inspection.

Pilgrim Hospital

Detailed findings

Services we looked at
Urgent and emergency services

Detailed findings

Contents

Background to Pilgrim Hospital

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We previously inspected the emergency department at Pilgrim Hospital in February 2018. We rated it as inadequate overall. Following our February 2018 inspection Under Section 31 of the Health and Social Care Act 2008, we imposed conditions on the registration of the provider in respect to three regulated activities. We took this urgent action as we believed a person would or may haven be exposed to the risk of harm if we had not done so. Imposing conditions means the provider must manage regulated activity in a way which complies with the conditions we set. The conditions related to the emergency department at Pilgrim Hospital, Boston.

We removed several conditions from the trust registration in June 2018 as part of the routine reporting we had seen improvements.

At the time of this inspection (30 November 2018) there were four conditions still in place on the trusts registration in relation to the emergency department at Pilgrim Hospital, Boston. The trust continues to report to us monthly.

Detailed findings

Our inspection team

The team that inspected the service comprised of Simon Brown, Inspection Manager, one other CQC inspector, and a national professional advisor with expertise in urgent and emergency care. The inspection team was overseen by Carolyn Jenkinson, Head of Hospital Inspection.

Facts and data about Pilgrim Hospital

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During the inspection, we visited the emergency department and the admissions areas which included the Integrated Assessment Centre (IAC), Ambulatory Emergency Care (AEC) and Acute Medical Short Stay Unit (AMSS). We spoke with 25 staff including registered nurses, health care assistants, reception staff, medical staff, and senior managers. We spoke with 12 patients and one relative. During our inspection, we reviewed 27 sets of patient records.

Urgent and emergency services

Safe	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

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Summary of findings

Our key findings were as follows:

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- We saw delays more than three hours for patients to be assessed by the medical team.
- We saw patients arriving by ambulance remained on the ambulance between 20-65 minutes waiting to enter the department. Whilst the patients remained under the care of the ambulance crew, there was no system in place to prioritise the patient who may have a high early warning score, indicating they may be sick.
- Whilst there was a "track and trigger" tool in place to monitor those patients who had been admitted to the department, staff did not always carry out observations in line with trust protocol and in a timely way. We saw critical observations go overdue for significant time periods. Patients who were at risk of deteriorating consciousness levels were not monitored effectively.

Urgent and emergency services

- There was no oversight of patients pre- and post-triage in the main waiting room and routine observations were not performed on these patients following triage.
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- Whilst beds had been identified for some patients, patients were not always moved from the ED in a timely manner.
- We saw there were significant issues in relation to patient flow which led to crowding and patients receiving care in corridors. Patients were experiencing unacceptable waits. Staff did not follow the escalation policy in use to ease and manage patient flow effectively.
- The nurse staffing levels and skill mix were not sufficient to meet the needs of patients. The department was under extreme pressure at the time of our inspection and we saw no action taken to assess nursing staffing levels were sufficient to meet the increasing capacity, demand or patient acuity issues.
- Children in the department were placed at risk of harm as they were not cared for by nursing staff with the necessary competencies to provide safe and effective care.
- Medical staffing was a mixture of junior, middle grade and registrar doctors, 80% of the medical workforce were locum. Despite the department being under extreme pressure at the time of our inspection we saw no action taken to assess medical staffing levels were sufficient to meet the increasing capacity, demand or patient acuity issues. We heard how some doctors had not had a break for the entire 12-hour shift.
- Leadership within the department was not effective. There was a lack of co-ordination between the consultant in charge, nurse in charge and site management team. The consultant in charge had no awareness of the increasing wait for senior review, rapid assessment and treatment area or ambulance handover delays.
- We found a culture of blaming overcrowding and low staffing levels / recruitment and use of agency staff for poor compliance with safety measures and poor practice. Nursing and medical staff used overcrowding as a rationale for lapses in care we identified during our unannounced inspection.
- The shift by shift management of risks, issues and performance in the Emergency Department (ED) was not robust. Our inspection team had to escalate several immediate patient safety concerns to medical and nursing staff to keep patients protected from avoidable harm. We also saw insufficient action to manage handover delays, overcrowding and poor staffing levels, this lead to poor patient experience

Urgent and emergency services

Are urgent and emergency services safe?

Environment and equipment

- The Emergency Department (ED) had one triage room, 10 major cubicles, three minor cubicles, one 'fit to sit' room, a see and treat room, a plaster room, a clean procedure room, four resus bays, three rapid assessment and treatment (RAT) cubicles, one waiting room and a quiet relatives room (which was also used as a mental health assessment room).
- The layout of ED was not suitable for the number of admissions the service received. During our inspection we saw a there was significant overcrowding in the department. We saw patients sat on the floor of corridors whilst receiving infusions of intravenous medication. The 'fit to sit' room was overcrowded, patients were sat on chairs and in wheelchairs, receiving intravenous medication. The room posed a risk to the evacuation of patients in the event of a fire or emergency, furthermore there was a risk to health and safety of people using this room as they may trip on drip stands.
- Throughout our inspection we saw patients being cared for on trolleys in the central area as there were no free cubicles to use. This meant patient privacy and dignity was comprised and there was a risk to safety as it would be difficult to evacuate the area in an emergency, or to assess and treat a patient who became unwell.
- We observed on many occasions how doctors were unable to sufficiently assess patient's conditions in the department, as there was no space to fully examine them. We observed a doctor carrying out an abdominal examination on a patient in the corridor. When we spoke with the doctor they told us there was no room to examine this patient and they were concerned about the patient's condition. We escalated this to the nurse in charge and the duty manager, who confirmed they would find a suitable area for the patient to be examined.
- We observed patients in the central area receiving care and treatment without the use of privacy screens. Throughout this inspection the department felt overcrowded and 'chaotic' and we observed, on many occasions, staff struggling to manoeuvre, beds and equipment due to the number of trolleys and beds within the department.
- We saw where resuscitation equipment was safe and ready for use in an emergency. Single-use items were sealed and in date and emergency equipment had been serviced. However, records indicated resuscitation equipment had not always been checked daily or weekly in line with trust policy. For example, we saw the resuscitation trolley in the major's area had not been checked for two consecutive days prior to our inspection. We raised this with nursing staff, who told us they would action this.
- The ED did not accommodate the needs of children, young people and accompanying families in line with the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings. There was no audio and visual separation of the children's waiting area from the adult section.
- The department had a dedicated children's cubicle / trolley space in the major's area, however we saw on numerous occasions adults were being treated in this area despite children requiring this cubicle / trolley space being in the department. We saw children arriving by ambulance were placed on trolleys along the corridor in the main department, with no attempt to prioritise the child for a suitable child friendly area. We observed a child placed between adult patients in the ambulance corridor, they had been there for over an hour when we observed their care.

Assessing and responding to patient risk

- During our inspection we observed significant handover delays for patients arriving by ambulance. We saw delays of patients waiting over three hours before being clinically assessed by the medical team. During our inspection we found 18 patients who had waited beyond the recommended 15 minutes to be clinically assessed. Time varied between 30 and 95 minutes. Data provided by the local NHS ambulance trust for the week prior to our inspection and up to the day of our inspection (30 November 2018) showed 778 patients attended pilgrim hospital. Of these, 556 (72%) of patients waited over 15 minutes to be handed

over to the trust. 144 patients were waiting between 30 and 59 minutes, 85 patients between 60 and 120 minutes and 31 patients between two and four hours. The average time to clinical handover was just over 34 minutes. The national standard is that 95% of patients should have initial assessment within 15 minutes of arrival to the department.

- The trust provided us with the streaming and triage figures for the six months preceding our inspection as below. The data differed from what is submitted to national data sets.
- We were provided with data from NHS Digital - A&E Quality in comparison to the national data set for ambulance arrival to initial assessment. From October 2017 to March 2018 the department performed worse than the England average. In April 2018 the department achieved the same median time for ambulance arrive to initial assessment as the England average.Between May and September 2018 the department performed worse than the England average.
- There was an inconsistent and ineffective system for monitoring patients in the ambulance corridor for any deterioration. A service level agreement was in place with the local NHS ambulance trust whereby ambulance staff had responsibility for patients until they were handed over to the trust.
- Following our inspection in February 2018, we imposed conditions on the registration of Pilgrim Hospitals emergency department under Section 31 of the Health and Social Care Act 200. This was becasue we found evidence to suggest the quality of health care in relation to handover delays and the monitoring of patients in the ambulance corridor required significant improvement. Following this inspection, the trust implemented the role of the Pre- Handover Practitioner (PHP). The aim of the PHP was to be the interface between arriving ambulance crews and the ED nurse and consultant in charge and applied to all patients brought in by ambulance crews where handover was delayed by 15 minutes or m
- During our inspection we found the department was to maximum capacity. We saw five patients arriving by ambulance remained on the ambulance between 20-65 minutes waiting to enter the department. Whilst the patients remained under the care of the ambulance crew, there was no system in place to escalate the patients who may have a high early warning score, indicating they may be sick. As a space became available, patients were brought into the ambulance corridor in arrival order rather than clinical priority. Ambulance crews told us if they were concerned about a patient, they would inform the ED nurse in charge, who would then decide if the patient could be brought into the department.
- During this inspection, we saw there was no PHP in place during the day shift, this role was being carried out by the nurse in charge. The role was not being carried out in line with the trust standard operating procedure. There was insufficient oversight of patients in the ambulance arrival corridor. During the night shift we saw a PHP was in place, however they were not adhering to the trust Pre-Handover Practitioner Standard Operating Procedure (SOP). When a hospital bed became available, patients were transferred from the ambulance trolley. The PHP then took a full handover from the ambulance crew documenting this as the triage time. The PHP then became responsible for the patients care as the ambulance crew left. The PHP SOP stated patients were to remain in the care of the transporting ambulance crew until they have been handed over to the ED clinician in charge, furthermore it stated the PHP will not take the nurse in charge role.
- We observed the practice of the PHP. They did not carry out their own initial assessment or observations of the patient when receiving handover. The PHP relied on the attending crew's information, including the early warning score. This posed a risk to patients as the PHP did not have the most up to date information.
- We saw the PHP did not communicate with the nurse or consultant in charge, this meant the nurse in charge did not have full overview of patient risk in the department.
- The department had three rapid assessment and treatment (RAT) cubicles for the early assessment of 'major's' patients arriving by ambulance. However, we saw the RAT process was ineffective at reducing ambulance handover times. Patients were waiting up to three hours before being assessed by the RAT team.

Urgent and emergency services

- The Royal College of Emergency Medicine (RCEM) 'Initial assessment of emergency department patients' suggests a detailed triage assessment should be made within 15 minutes of the patient's arrival. We reviewed the ED records for 20 patients. Time from arrival to triage varied between seven and 40 minutes. Our review of records showed six patients waited 15 minutes or less, nine patients waited between 15 and 30 minutes and five patients waited between 30 and 60 minutes. The average time to triage was 19 minutes.
- The triage process was not effective in early detection of acutely unwell patients. Staff used a categorisation scale of one to five (one being immediate priority and five least priority). We saw patients such as a patient with a diabetic ketoacidosis (DKA) categorised as a category three when they should have been categorised as category one (immediate priority). They were initially sent to the minor's area of the department when they should have been in the resuscitation or majors area of the department. Diabetic ketoacidosis (DKA) is a serious problem that can occur in people with diabetes if their body starts to run out of insulin. This causes harmful substances called ketones to build up in the body, which can be life-threatening if not spotted and treated quickly. We also saw a child with potential sepsis was also categorised as a category three when they should have been categorised as category one (immediate priority). Sepsis is a serious complication of an infection. Without quick treatment, sepsis can lead to multiple organ failure and death.
- Following triage, triage staff used a "red flag" card which was attached to the patient's records. The "red flag" indicated this patient needed to see a doctor ahead of other patients who may not have a "red flag". We saw this process was ineffective, doctors demonstrated little awareness of the "red flag" system, and did not prioritise "red flag" patients. We had to alert doctors to patients who had been "red flagged" as they had not been seen in a timely manner. At the time of reviewing the notes two patients had waited over 65 minutes to be seen by a doctor, there had been no monitoring of the "red flag" process by the consultant in charge, nurse in charge or triage nurse.We alerted a doctor to a third "red flag" a young child who had presented with possible sepsis. The child had been red flagged for 75 minutes when we reviewed the notes. The doctor told us they could not see the patient and they were better seen by a "more senior" doctor, and that they would ask the consultant in charge to see the patient. The child had not been seen ten minutes later, we alerted the nurse in charge who ensured the child was reviewed immediately by the consultant in charge.
- There was no oversight of patients pre- and post-triage in the main waiting room. The triage staff told us reception staff would alert the triage nurse or nurse in charge if they were alerted to or felt the patient was deteriorating. Reception staff were not clinically trained and could not visualise all areas of the waiting room. On our arrival to the department, we observed a relative alert the reception staff that their relative "felt faint". Whilst reception staff immediately alerted nursing / medical staff in the department, the response to the situation was delayed.
- During our inspection we carried out a 20-minute observation of the waiting room. We saw patients who following triage should have been moved straight into the major's area of the department, were seated in the waiting area, for example a patient with possible DKA, a child with possible sepsis and a patient with a bleeding wound. We asked triage staff the rationale for this, they informed us this was due to "capacity" in the department. We asked if this had been escalated to the nurse in charge or the site duty manager, they said no. We alerted the nurse in charge to this, who said she would try and create capacity.
- We observed a patient with abdominal pain wait over four hours to be clinically assessed by a doctor. The patient was then examined in the corridor. Imaging showed the patient had a bowel obstruction. The doctor informed us they were unable to appropriately examine the patient, as they had no area to do so. We saw the patient had not been offered any pain relief, or started on an intravenous fluid. We asked the doctor if they had raised the capacity issue with the nursing or consultant in charge, they informed us they had but they had been unable to establish capacity. We raised our concerns immediately with the site duty manager and senior manager "silver" on call, who said they would look to create capacity for this patient as soon

as possible. A bowel obstruction, is a serious problem that happens when something blocks the bowel. Untreated, bowel obstructions can cause serious, life-threatening complications.

- A national early warning scoring system (NEWS) and paediatric early warning scoring system (PEWS) were not routinely used as part of the triage process. An early warning score is a guide used by healthcare staff to quickly determine the degree of illness of a patient and prompts support from medical staff and/or senior nursing staff when required. We reviewed ED records for 20 patients and found that NEWS / PEWS had not been completed at the initial assessment (where required) in eight records.
- Once in the main ED nursing staff used NEWS and PEWS to record routine physiological observations such as blood pressure, temperature, respiratory rate and heart rate. Observations were recorded electronically and included a 'track and trigger' system whereby scores were displayed visually within the department. Staff did not always carry out observations in line with trust protocol and in a timely way. We saw occasions where patient's observation were overdue. Whilst a warning note "critical patient's overdue observations" was present on the main department screen, staff did not respond to this. For example, we saw how a patient with a NEWS score of eight indicating they may be sick, was overdue observations by one hour and 52 minutes, and another patient with a NEWS of five was overdue by 20 minutes. We escalated our concerns to the nurse caring for these patients who arranged for observations to be carried out.
- Staff did not manage the deteriorating patient well. We reviewed the records of a patient who had been admitted with chest pain at 11am. They had been allocated to the treatment room of the department and seen by a doctor at 12:40. The patient suffered a cardiac arrest one hour later.
- We saw an example from medical records of a patient who waited 113 minutes to be seen by a doctor. An hour after the doctor review, a documented entry in the records by a nurse stated that on walking past the room they had heard the alarm from the monitor. On reviewing the patient, they found that the patient had an altered conscious level, they informed the nurse in charge, and it was documented there appeared to be little regard to this. The patient was subsequently moved to the resuscitation area with a NEWS score of 18 and a Glasgow Coma Score of Nine.
- Patients who were at risk of deteriorating consciousness levels were not monitored effectively. We observed the care of two patients with head injuries. Despite medical records indicating neurological observations should be performed at regular intervals, these had not been completed. We alerted a nurse caring for the patient of this, who carried out these observations immediately. One patient had been in the department for six hours without these observations. Neurological observations are essential to establish the patient's neurological status and to illustrate any changes.
- There was significant overcrowding in the emergency department. At the time of our inspection some patients had remained in the emergency department at Pilgrim Hospital for over 10 hours. We saw eight patients had waited on hospital trolleys for between seven and 11 hours. Patients did not always have a pressure area assessment score carried out and were not always placed on pressure relieving mattresses in a timely manner, despite their clinical assessments indicating they were at risk of tissue damage. We saw in one patient's notes that it was recorded "unable to assess patients pressure areas due to no assistance available". There were no further entries to suggest this had been escalated. We escalated this to the nurse who said she would arrange for the patient to be placed on an appropriate mattress. We also asked nurses caring for patients who we had concerns about to change the position of patients to minimize the risk of pressure damage.
- Since our last inspection the department had implemented a safety checklist and care rounding checklist. This had many actions that staff must complete in each of the hours the patient was in the department. Checklists were reviewed for 10 patients indicating that these were inconsistently completed. We found in many records no evidence of patients being offered food and drink or pressure relieving care. There was no oversight of the completion of these records by the nurse or doctor in charge.

- We observed on many occasions patients being taken to other departments by porters without a nurse escort / medical escort. For example, patients on cardiac monitors and receiving intravenous medications. This put patients at risk of avoidable harm as staff may not be trained to recognise any complication with the infusions during transfer.
- We observed nursing staff regularly leaving the department to take patients to ward areas. There was no cover for them or the patients they were caring for whilst out of the department, nor did they hand over to the nurse in charge. We saw on one occasion three nurses left the department at the same time (one from the resuscitation area, and two from the major's area) one nurse was gone for a total of 28 minutes. We asked the nurse who had been caring for her patients whilst she was away. They were unaware of the cover arrangements.
- We saw interventions such as blood glucose testing, urine sample collection and commencement of specialist treatment plans / care pathways were not always carried out in a timely manner. We saw a patient waited two and a half hours following a senior clinical review to been commenced on a diabetic ketoacidosis pathway, despite presenting to the department three hours and 42 minutes earlier.
- Patients were not seen by senior clinician in a timely way. During our inspection we reviewed the care and treatment of 20 patients. Patients were waiting between 14 minutes and up to four and a half hours to be seen by a doctor. The average time for patients to be seen by a senior clinician during our inspection was one hour and 46 minutes. Patients were not always seen in priority order and we saw patients who we would have expected to have a clinical review immediately were not seen in a timely manner, for example we saw a patient with an acute bowel obstruction wait for over four hours and a patient with a DKA waited for one hour and 42 minutes.

Nurse staffing

- The nurse staffing levels and skill mix were not sufficient to meet the needs of patients. During the first part of our inspection (on the day shift) there was no dedicated nurse to those patients arriving by ambulance who would remain on the corridor. The nurse in charge was carrying out this role, whilst trying to co-ordinate flow in the department and support nursing and support staff.
- Nurses were escorting patients to wards and CT scans which left the remaining patients without a nurse for long periods of time.
- The department was under extreme pressure at the time of our inspection and we saw no actions taken to assess nursing staffing levels were sufficient to meet the increasing capacity, demand or patient acuity issues.
- At the time of our inspection the nurse in charge told us that the planned versus actual staffing had not been achieved. The planned number of nurses for the day shift was 11 nurses supported by five healthcare assistants. The staffing levels at the time of our inspection was seven nurses and three healthcare assistants. Two nurses were from other wards. There was a 50% substantive staff to 50% agency staff on the shift.
- The night shift had achieved the planned eight nurses and four healthcare assistants.
- At our last inspection we raised concerns the department did not have a minimum of one children's nurse present on each shift in line with the 'Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings' document titled, "Standards for Children and Young People in Emergency Care Settings" (2012) which recommended that 'all nursing staff should have minimum competencies including recognition of the sick or injured child, basic life support skills, the ability to initiate appropriate treatment in accordance with locally agreed protocols'. Registered nurses (adult) had not received additional competencies above and beyond paediatric resuscitation training to provide them with the skills required to recognise a child whose condition may be deteriorating. The trust had worked to address this and had supported 75% of the nurses working in the department to complete and attain additional competencies to care for children.
- At the time of our day and night time inspection there were two nurses on each shift who had the necessary competencies for care for children, in addition to the

nurse in charge who had completed Emergency Paediatric Advanced life support. At the time of our inspection we observed there were five children who had / were receiving care in the department. One (a child in the resuscitation room) out of five children were cared for by those nurses with the necessary skills and competencies. Children in the department were placed at risk of harm as they were not cared for by staff with the necessary competencies to provide safe and effective care.

- The trust provided us with the percentage of nursing shifts in the Emergency Department filled with agency staff between June and November 2018. The percentages varied between 37% (July and November 2018) and 45% (October 2018). Bank staff shift were covered for 11% (June 2018) and remained static at 9% for the remaining months July - November 2018.
- For each month between June and November 2018 total nursing shifts covered by bank and agency staff varied between 46% (November 2018) and 54% (October 2018). The trust told us this was due to a high registered nurse vacancy level and a lack of children's nurses in the department. They informed us that many of the agency nurses working in the department were regular agency staff.
- The percentage of shifts covered by substantive staff between June and November 2018 varied between 60% (July 2018) and 51% (October 2018). This meant that on each shift the nursing workforce was likely to be made up of almost half agency/bank.
- We asked the trust to provide us with the percentage of nurses who had Paediatric Immediate Life Support (PILS) qualification. Data supplied was that 61.53% of nurses had this qualification. The trust target was 90%.
- We asked the trust to provide us with the percentage of nursing and unregistered nurses who had Immediate life support qualification (ILS). Data supplied was that 66.6% of registered nurses and 42% of unregistered staff were trained in ILS. The trust target was 90%.
- Following our inspection, the trust told us that there was a significant programme of education underway to ensure all staff had the correct life support training. They informed us the reason for the low percentage levels of staff having completed this training was due to new starters in the department.

Medical staffing

- At the time of our inspection there was consultant presence in the emergency department.
- Medical staffing was a mixture of junior, middle grade and registrar doctors, 80% of the medical workforce were locum. The rota was worked around 16 medical staff.
- All patients being seen by a foundation year two doctor required a discussion with a senior member of the medical team prior to discharge. All patients seen by foundation year one doctors had to be physically seen by a senior member of the medical team prior to discharge.
- During the night shift there were two middle grade doctors, supported by junior doctors. At least one middle grade was trained in Advanced Paediatric Life Support.
- The department was under extreme pressure at the time of our inspection and we saw no actions taken to assess medical staffing levels were sufficient to meet the increasing capacity, demand or patient acuity issues.
- We heard from many doctors on shift at the time of our inspection, who had been on shift for over 12 hours without a break.
- The trust provided us with the percentage of medical shifts in the Emergency Department filled by agency locum between July and November 2018. The was a variance in the figures with the highest percentage 32.4% being in June 2018 and the lowest in July 2018 (20%). Other months figure were static between 27% and 30%.
- We ask the trust for the percentage of medical staff who were in date with advanced life support (ALS), emergency paediatric advanced life support (EPALS) and advanced paediatric life support (APLS). Data was as follows 80% of consultants and middle grade doctors had an ALS qualification, however only 25% of bank middle grade doctors had this qualification.

EPALS / APLS qualification was held by 100% of the consultants, 80% of the middle grade doctors and 25% of bank middle grade doctors. The trust target was 90%.

Medicines

- We reviewed 12 medicine administration records. Our review showed patients were not always getting their medicines in a timely manner and when they needed them. Doctors did not always communicate effectively with nursing staff when they had created a plan, prescribed a treatment or wanted an intervention for a patient. We saw four patients who required medication administering, doctors had not alerted this to the nursing staff. We alerted nursing staff to the medication during our notes review and requested they review and administer this if this was what was required. Nursing staff told us that doctors often didn't put the notes in the "treatment" slot which was one of the causes of "missing things". One of the medications had been prescribed whilst nursing staff were away from the department. Two of the medicines were time-critical medication. Time-critical medications are those where early or delayed administration of maintenance doses of greater than 30 minutes before or after the scheduled dose may cause harm or result in substantial sub-optimal therapy or pharmacological effect.
- We found the medicines fridge in the major's area had not had a temperature check for seven out of the 30 days in November. We were therefore not assured medicines requiring refrigerated storage were stored appropriately and within recommended temperature ranges and may not be suitable for use. We escalated this to the nursing team at the time of our inspection, who said they would act to address this.

Are urgent and emergency services caring?

Compassionate care

- We spoke with 12 patients and one relative during our inspection of the Emergency Department (ED). Feedback was mixed with the majority being poor. Patients described staff as being too busy to respond to some of their basic needs, although said staff were apologetic for this. Most patients commented on the poor environment, how busy the staff were and how long they had to wait for treatment. Patients being cared for in the middle of the department described feeling "exposed". One patient in the corridor described feeling like they were in a "war zone". Patients in the "fit to sit" area described how they felt "forgotten". Patients did however mostly describe their interactions with nursing and medical staff as positive with staff portraying a caring attitude and apologetic nature for the situations they may have encountered. We observed the time staff spent with patients was limited because they were so busy and staffing numbers were insufficient to meet the demands of the service.
- During this inspection, we found significant overcrowding in the ED. This meant patients privacy and dignity needs were not always respected. We saw many patients being treated in the middle area of the department, on corridors and in rooms that were not designed for treatment, such as the relatives room. Patients in the corridor and in the middle area of the department did not have access to a patient call bell and as such, would not have been able to easily call a nurse for assistance. We also saw patients nursed adjacent to an outside exit door which was constantly opening and closing. The corridor was cold.
- Ambulance staff transferred patients from the stretcher to trolley in an open area adjacent to an opening door. Ambulance staff told us that they were not meant to do this, however there were no cubicles available to facilitate this.
- We saw patients, whilst cared for by ambulance crews were left on the back of ambulances for long periods. This was due to lack of capacity in the department. This did not afford patients the dignity they deserved.
- We observed many examples where patient's privacy and dignity needs had not been met appropriately. We saw patients being examined in corridors, patients having interventions (such as cannulas removed) on corridors or in areas unsuitable for the interventions.
- We observed the care of one patient cared for in the middle of the department, was removed from the

department by security staff. The patient was not treated with kindness, dignity and respect by security staff, despite being "visibly friendly". Medical staff referred to the patient as a "regular".

- Care rounding documentation was inconsistently completed and patients went for long periods without any staff checking on them, our own observations supported this.
- We observed patients who were living with dementia becoming distressed in the department and screaming out, staff did their best to support the patients in a way that would ease the anxiety, however the nature of the environment did not allow this to always be successful.
- We heard many frail elderly patients calling out from behind curtains in cubicles. There was a lack of regard for this and the noises were often ignored by nursing, medical and support staff, and we had to ask on many occasions if staff could assist patients. Not all patients had access to call bells.
- Patients were not always offered timely pain relief despite their presenting conditions.

Understanding and involvement of patients and those close to them

- We spoke with four patients, who described not knowing what was happening to them despite being in the department for significant lengths of time. They said they could see staff were busy and did not want to disturb them.
- We observed many patients / relatives displaying angry behaviour towards nursing and medical staff, whilst staff dealt with this in a professional manner, the angry behaviour could have been avoided had patients / relative been kept informed of the care and treatment plans.

Are urgent and emergency services responsive to people's needs? (for example, to feedback?)

Access and flow

- At the time of our inspection the hospital was on Operational Pressures Escalation Level (OPEL) 3. OPEL provides a nationally consistent set of escalation levels, triggers and protocols for local A&E Delivery Boards and ensures an awareness of activity across local healthcare providers. Escalation levels run from OPEL 1; The local health and social care system capacity is such that organisations can maintain patient flow and are able to meet anticipated demand within available resources to, OPEL 4; Pressure in the local health and social care system continues to escalate leaving organisations unable to deliver comprehensive care.
- Since our last inspection the trust had opened an Integrated Assessment Centre (IAC) with an aim to improve flow through the department. IAC also included eight ambulatory care chairs. The trust had also opened 24 beds on an acute medical short stay unit (AMSS).
- During our inspection we visited the receiving IAC and AMSSU. We saw there had been a bed empty on AMSSU for three hours with no patient being identified for this. Staff told us they were waiting for patients to have a "senior review" on IAC before being transferred.
- Patients arrival time and decision to admit time were recorded and monitored on an electronic system, this meant there was oversight of the amount of time patients spent in the department and to ensure timely transfer to ward areas. We saw following our arrival site managers and a senior manager "silver" present in the department attempting to "restore flow" by co-ordinating patient's admission to ward areas. Whilst beds had been identified, patients were not always moved from the ED in a timely manner. Staff told us this was due to a lack of porters. We saw one porter in the department at the time of our inspection.
- We visited IAC and staff told us there was sufficient senior clinical staff reviewing patients and making plans. IAC staff identified suitable wards for patients to be sent to once assessed by a clinician.
- We saw many patients who were nursed in corridors or in the "fit to sit" area who may be suitable for ambulatory care. Nursing staff on IAC told us they could only take patients of the "same sex".
- There was an ineffective system in place for those patients who were clinically stable referred by a GP. Due to the lack of a clinical assessment in a timely way

by medical staff, we saw these patients remained in the department for a significant amount of time and were not sent to a surgical or medical assessment unit within 30 minutes of arrival.

- During our inspection the average time of arrival to receiving treatment at Pilgrim Hospital's Emergency Department (ED) was a median of one hour and 48 minutes.
- Three rapid assessment and treatment (RAT) cubicles were available for the early assessment of 'major's' patients arriving by ambulance. The RAT process was carried out by a senior doctor, registered nurse and health care assistant. The RAT process was ineffective at reducing ambulance handover times. At the time of our inspection the average time patients were waiting for RAT was two hours and nine minutes. Once patients had been assessed by the RAT team, they often remained in the RAT cubicles for a significant amount of time as there was no space in the department for their ongoing care, this delayed the RAT of other patients.
- There was a lack of speciality medical support within the hospital. Medical staff told us and we saw how they struggled to refer patients from the ED to a speciality such as medicine. We saw how one doctor bleeped the medical team 12 times before being successful, this was approximately one hour and 43 later.
- Data supplied by NHS England showed 36% of patients waited 4-12 hours from the decision to admit to admission in October 2018, compared to 12% nationally. Data from NHS England also showed significantly worse than the 95% target and worse than the England average for patients spending less than four hours in the emergency department. In October 2018 67% of patients spent less than four hours in the Emergency Department compared to 87% nationally, and 62% of patients in type 1 major A&E spent less than four hours in the department compared to 83% nationally.
- Data also showed much worse than the England average for patients spending less than four hours in the emergency department.

Are urgent and emergency services well-led?

Leadership

- At the time of our focussed inspection leadership within the department was not effective. There was a lack of co-ordination between the consultant and nurse in charge with the nurse in charge taking the main lead in the department.
- The consultant and nurse in charge did not communicate on a regular basis, and we saw no discussions in relation to flow, despite an increasing demand on the department.
- Following our arrival to the department, we saw many senior leaders in the trust arrive in the department. Whilst the senior support was welcomed by staff, this was not always effective in creating a management plan for the department.
- Whilst leaders demonstrated an awareness of the challenges within the ED there did not appear to be one individual taking overall responsibility for the day to day running of the department. Our inspection team had to escalate many immediate patient safety concerns to medical and nursing staff to keep patients protected from avoidable harm.
- At the time of our inspection we were told that there was no substantive matron or clinical lead in post for the emergency department at Pilgrim Hospital, however they received one day per week support from the head of service at the other hospital site. Recruitment was ongoing.

Culture

- We found there was a culture of blaming overcrowding and low staffing levels / recruitment and the use of agency staff for poor compliance with safety measures and poor practice. Nursing and medical staff used overcrowding as a rationale for lapses in care we identified during our unannounced inspection.
- There was a culture of acceptance of the current working practices in the department. For example, we heard many frail elderly patients calling out from behind curtains in cubicles. There was a lack of regard

for this and the noises were often ignored by nursing, medical and support staff, and we had to ask on many occasions if staff could assist patients. Not all patients had access to call bells.

- We saw an example from medical records of a patient who wasn't seen by a doctor for 112 minutes. An hour following review, a documented entry in the records by a nurse stated that on walking past the room they had heard the alarm from the monitor. On reviewing the patient, they found that the patient had an altered conscious level, they informed the nurse in charge, and it was documented there appeared to be little regard to this. The patient was subsequently moved to the resuscitation area with a NEWS score of 18 and a Glasgow Coma Score of Nine.

Managing risks, issues and performance

- The shift by shift management of risks, issues and performance in the Emergency Department (ED) was not robust. Our inspection team had to escalate many immediate patient safety concerns to medical and nursing staff to keep patients protected from avoidable harm. We also saw insufficient action to manage handover delays, overcrowding and poor staffing levels this lead to poor patient experience.
- We saw there were significant issues in relation to patient flow which led to crowding and patients receiving care in corridors. Patients were experiencing unacceptable waits. Staff did not follow the escalation policy in use to ease and manage patient flow effectively.
- The information used to monitor performance or to make decisions was inaccurate, invalid, unreliable, out of date or not relevant. For example, the trust provided us with the streaming and triage figures for the six months preceding our inspection. The data differed from what was submitted to national data sets.