University Hospitals Plymouth NHS Trust

Derriford Hospital

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out an unannounced focussed inspection of the emergency department at Derriford Hospital on 15 April 2019.

We did not inspect any other core services or wards at this hospital or any other locations provided by the trust. We did visit the day case recovery unit which was being used to provide additional overnight patient accommodation as part of the trust's escalation plan. During this inspection we inspected using our focussed inspection methodology. We did not cover all key lines of enquiry. We did not rate this service at this inspection.

The trust has one emergency department which provides a 24-hour, seven day a week service. It is a designated major trauma centre providing care for the most severely injured trauma patients from across the south west.

Our key findings were as follows,

- There were not enough available beds in the hospital to allow emergency patients to be admitted to a ward as soon as this was required. This had resulted in a crowded emergency department with patients receiving care and treatment in unsuitable environments.
- Initial clinical assessment (triage) of patients did not take place according to guidance produced by the Royal College of Emergency Medicine and the Royal College of Nursing. Self-presenting patients sometimes waited for up to an hour to be triaged. There was a risk serious medical conditions could remain undetected with a consequent delay in treatment.
- Some records of patient observations were not accurate.

However:

- Patients arriving by ambulance were assessed and treated quickly.
- There was a supportive and friendly culture within the department which was centred on the needs of patients.
- Innovative ideas had been used to prevent unnecessary admission to hospital.
- The emergency department had a committed and well-motivated leadership team.

We told the trust they must:

- Reduce crowding in the emergency department so patients do not have to wait on trolleys in unsuitable environments.
- Complete initial assessment (triage) of self-presenting patients in accordance with standards set by royal colleges.
- Accurately record first clinical observations made by emergency department staff.

In addition, the trust should:

- Improve and monitor the speed of response from senior specialist doctors when patients have been referred to them by the emergency department.
- Regularly monitor operational performance in the emergency department at a senior level and record issues, including how these are being addressed.

Professor Edward Baker

Chief Inspector of Hospitals

Derriford Hospital

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Our inspection team

The team included a CQC inspector, a consultant in emergency medicine and a specialist advisor in emergency nursing.

The inspection was overseen by Mary Cridge, Head of Hospital Inspection.

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Information about the service

The emergency department (ED) is a designated major trauma centre and sees approximately 100,000 patients a year. It consists of a major treatment area with eleven cubicles and four side rooms, a resuscitation area with facilities for four patients, an ambulance assessment area with three assessment bays and a minor treatment area with four cubicles.

There are separate rooms for mental health assessment, eye examinations and application of plaster casts. A clinical decision unit provides 10 beds for patients who need a short period of observation while awaiting the results of major investigations such as computerised tomography (CT) scans. The unit also has a lounge for patients who are well enough to sit while waiting for test results.

Children have a separate treatment area with five individual treatment rooms and separate waiting areas for small children and adolescents.

We last inspected the emergency department in April 2018 as part of our ongoing inspection programme. The service was rated as requires improvement overall.

Summary of findings

Our key findings were:

- There were not enough available beds in the hospital to allow emergency patients to be admitted to a ward as soon as this was required. This had resulted in a crowded emergency department with patients receiving care and treatment in unsuitable environments.
- Initial clinical assessment (triage) of patients did not take place according to guidance produced by the Royal College of Emergency Medicine and the Royal College of Nursing. Self-presenting patients sometimes waited for up to an hour to be triaged. There was a risk serious medical conditions could remain undetected with a consequent delay in treatment.
- Some records of patient observations were not accurate.

However:

- Patients arriving by ambulance were assessed and treated quickly.
- There was a supportive and friendly culture within the department which was centred on the needs of patients.
- Innovative ideas had been used to prevent unnecessary admission to hospital.
- The emergency department had a committed and well-motivated leadership team.

Urgent and emergency services

Are urgent and emergency services safe?

As this was a focused inspection we have not inspected the whole of this key question. Therefore, there is no rating.

Environment and equipment

- The department had recently undergone a major refurbishment programme with newly built children's facilities, resuscitation area and ambulance assessment area. The latter was also known as the FLIC (front-loaded initial consultation) area and had opened four weeks before our inspection.
- The children's treatment area had secure access and ensured children were not exposed to the disturbing sights and sounds that sometimes occur in an adult emergency department.
- Senior staff had improved the medicines preparation areas since our last inspection. All were now secure and separate from patient areas.
- Most areas of the department had been designed to ensure staff had good visibility of patients. The exceptions were the four side rooms in the major treatment area which were used for patients with potentially infectious illnesses. Staffing levels for this area had been adjusted to ensure frequent observation of patients.
- Due to poor patient flow though the department there were not always enough cubicles or rooms for adult patients. As a result, some patients had to wait on trolleys in an open area in the centre of the department.
- As the department became busier trolleys were placed in a row with no space between them. It was difficult for nurses to reach some patients to undertake observations of vital signs, such as blood pressure and pulse rate.
- In the late evening during our inspection there was no room left in the centre of the department and one patient had to be placed next to the staff base. These areas were cramped, busy and noisy and did not provide a therapeutic environment for emergency patients.
- If it was not possible to move patients out of the ambulance assessment area, newly arrived ambulance patients sometimes waited in the central area. However, they had been fully assessed by an experienced nurse, had normal vital signs and were not in pain.
- All patients in the central area were observed by clinical staff at all times. Patients told us staff had explained why they were waiting there. Some of them felt uncomfortable in the area but they accepted ED staff were doing all they could to improve the situation.
- Although most patients were in the central area for less than an hour, some patients had to wait two or three hours before they could be moved to a ward. If they required further treatment or intimate care they were moved temporarily into a curtained cubicle.
- There was a designated room for seeing patients who required a mental health assessment. This had recently been modernised so it met the Psychiatric Liaison Accreditation Network quality standard requirements.
- An adjacent imaging department provided X-rays and scans. The department had its own CT (computed tomography) scanner next to the resuscitation area.
- We checked a range of specialist equipment, including adult and children's resuscitation equipment. It was clean, tamper-evident, clearly organised and well maintained. It had been checked daily to ensure it was ready for use.

Assessing and responding to patient risk

- Patients arriving by ambulance as a priority (blue light) call were taken immediately to the resuscitation area. These patients were phoned through in advance so an appropriate team could be alerted and prepared for the arrival.
- Other patients arriving by ambulance were assessed by an experienced nurse as soon as they arrived. The assessment was needed to determine the severity of illness or injury and to prioritise the speed and type of treatment required. This is often known as triage.

- Patients who walked into the department, or who were brought by families or friends, reported to the reception desk.Once initial details had been recorded patients were asked to sit in the waiting room while they waited to be assessed by a nurse.
- We observed the initial assessment of four patients (with their consent) and found it to be thorough and methodical. The nurse had completed training in triage and had been assessed as competent before undertaking the role.
- The triage process did not fully comply with standards set by the Royal College of Emergency Medicine and the Royal College of Nursing. These state " and should normally require less than 5 minutes contact". During our inspection the assessment often took 10 minutes to complete, which delayed other patients who were frequently arriving in the department, and some patients waited up to an hour for triage.
- During our inspection there were 14 patients waiting to be triaged at 7pm. None of them were assessed within 15 minutes. We observed four patients in detail. They waited between 48 and 58 minutes to be triaged and there was a risk their condition could deteriorate in this time. One patient was found to have a very low blood pressure and required immediate medical treatment. The matron was aware of this problem and was developing plans to change the assessment process.
- The National Early Warning Score (NEWS2) was used for adults. This was a quick and systematic way of identifying patients who were at risk of deteriorating. Clinical observations such as blood pressure, heart rate and respirations were recorded and contributed to a total score. Once a certain score was reached a clear escalation of treatment was commenced. We reviewed the NEWS charts of 21 patients and found all but two had patients had been monitored according to best clinical practice. However, delays in the triage of patients meant the first calculation of the NEWS was not always done quickly enough and opportunities for identifying deteriorating patients were potentially missed.
- Paediatric early warning scores (PEWS) were used for children. Different methods of scoring were used for different ages of children in accordance with best practice. Only two children required PEWS when we inspected the children's treatment area. However, both had been calculated correctly.
- If a patient had an early warning score of five or more, they were screened for sepsis (a critical medical condition resulting from a serious infection). We looked at the records of three patients with high scores and found they had all been screened correctly.
- Nurses in the department used a patient safety checklist. This was aimed at reminding nursing staff to undertake two-hourly safety checks of all patients in the major treatment area. We looked at the safety checklists of seven patients who had been in the department for four hours or more. Five of the seven checklists had been fully completed.
- The monthly records audit for March 2019 showed 91% of safety checklists had been completed correctly.
- Nursing staff told us there were new risk assessments for patients who attended as the result of a fall.We reviewed the records of two patients and found both had been assessed for the risk of further falls. Nurses had increased the frequency of observation to help reduce the risk.
- Risk assessments had taken place before patients were placed in the centre of the department. Most had been treated by an emergency department doctor, their condition was stable, and they were waiting to be admitted to a ward.

Records

- When ambulance patients arrived, emergency department staff would record the last set of vital sign observations made by the ambulance service. However, on the patient's record, they did not make it clear when the observations had been taken, or by whom. Therefore, it appeared the observations had been recorded during the initial assessment on arrival at the emergency department. This was misleading and was likely to lead to a delay in further observations of vital signs. We observed the same

practice during our last inspection in April 2018. We brought this to the attention of ED staff at the time and an action plan was put in place. However, very little improvement had taken place.

- We reviewed 21 patient records in total. All other aspects of the records were written and managed in a way that kept patients safe.

Nursing staffing

- A review of nurse staffing levels had been undertaken in 2018 although it was not clear whether an evidence-based staffing tool had been used. The review indicated 13 registered nurses were needed during the day and 11 at night.
- We reviewed staff levels for a random selection of nine days and nights between 9 January and 26 March 2019 and found these staffing levels had been achieved.
- The children's treatment area was separately staffed. There had been an increase in registered children's nurses employed by the department. Planned paediatric nurse staffing levels were increased in line with recommendations from the royal college at the beginning of September 2018. From the beginning of March 2019 this had been achieved, and there had always been a minimum of two registered children nurses on duty. This met guidance contained in the intercollegiate standards for children in emergency settings.
- Following a recent recruitment exercise there were very few vacancies for nursing staff. This meant the department did not have to employ temporary agency nurses.

Medical staffing

- There was a consultant in the department from 8am to midnight, seven days a week. There were two consultants in the department until 10pm.
- We looked at the rota for the month before our inspection and saw, when there were no consultants in the department, there was a senior middle grade (ST4 or above) on duty. For most nights there were two senior middle grade doctors in the department. There was a consultant on-call from home at night.
- Junior doctors spoke positively about working in the emergency department. They told us the consultants were supportive and accessible. There had been a well-organised induction programme. In-house teaching took place twice a week and was comprehensive and well organised.

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

As this was a focused inspection we have not inspected the whole of this key question. Therefore, there is no rating.

Access and flow

- There were not enough available beds in the hospital to allow emergency patients to be admitted to a ward as soon as a bed was required. When we arrived, there were six patients lined up in the centre of the major treatment area, waiting to be admitted to a ward.
- Throughout our inspection there were never less than five patients in this space and by 7pm there were 10 patients. Most were waiting to be admitted to a ward, but no beds were available.
- There were arrangements in place to try and reduce the crowding in the department. For example, patients who had been urgently referred to specialist doctors by their GP went directly to a special assessment unit. However, by 4pm we found this unit was full and not able to accept any further patients. The result of this was that these patients were sent to the emergency department where they sometimes waited for several hours. ED staff told us the assessment units were often full by the middle of the afternoon.
- Low-risk patients waiting for a specialist doctor sometimes waited in the clinical decision unit. We observed a patient who had been waiting there for three hours to see a maxillo-facial surgeon (mouth, jaw, face and neck specialist). Nursing staff could not say how much longer the patient would have to wait.
- After assessment in the FLIC (front-loaded initial consultation) area, doctors could send frail and complex patients directly to the frailty unit. This was staffed by a multi-disciplinary team who worked closely with community teams to enable frail patients to be treated at home if it was safe to do so.

Urgent and emergency services

- There was an ambulatory emergency care (AEC) unit which provided urgent day case medical treatment. This helped to prevent unnecessary admission to a ward for patients with straightforward illnesses that could be treated quickly. The unit was open from 8am-8pm five days a week.
- The frailty and AEC units had a dedicated transport service that ensured patients could be brought back to the hospital at specific times if they needed follow-up treatment or urgent appointments. It also allowed frail patients to be returned home quickly so home support could be co-ordinated more effectively.
- The emergency department had a patient flow co-ordinator who monitored the progress of patients in the emergency department and made sure they did not "get lost in the system". The co-ordinator informed clinical staff when the results of investigations had been received or if there were delays in admission to a ward.
- The Department of Health's emergency access standard is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department. Despite many initiatives, the trust had been unable to meet this standard since November 2016. During our inspection some patients had been in the department for up to nine hours. Most had been seen and treated by ED staff within one hour. Delays started to occur when they needed further specialist treatment or required admission to a ward. Once a senior doctor ED had decided that a patient needed further specialist treatment, the patient would be transferred to an assessment unit. However, the assessment units were often full and so referred patients had to wait in the emergency department.
- Figures from NHS England showed from January to March 2019, 64.4% of patients were admitted or discharged within four hours. This was worse than the national average of 77.2% for similar types of emergency departments. However, there had been gradual improvements during that period and 78.3% of patients spent less than 4 hours in the department in March 2019.
- The same figures showed the reasons for most delays were for patients waiting to be admitted to a ward. However, very few patients had waited more than 12 hours to be admitted.
- We attended a bed management meeting at 5pm where senior hospital managers made arrangement for the admission of patients to the hospital. Although they could identify empty beds for six of the patients waiting in the emergency department, the beds were not immediately available. It was not clear when the patients would be moved to a ward or where the remaining patients waiting in the emergency department would be treated.
- The bed management team used the national Operational Pressures Escalation system (OPEL). We were told the hospital was on Operational Pressures Escalation Level (OPEL) three. This refers to the number of beds available in the hospital and the number of patients needing to be admitted. OPEL provides a nationally consistent set of escalation levels, triggers and protocols for hospitals 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.
- The actions to be considered at OPEL 3 status include "Enact process of cancelling day cases and staffing day beds overnight if appropriate" and "Active management of elective programme including clinical prioritisation and cancellation of non-urgent elective inpatient cases".
- The trust's escalation plan included the use of the day case operating theatres recovery area as additional overnight patient accommodation. The recovery area had room for 14 patients, and a maximum of 10 spaces initially could be used for overnight patients, with further escalation to 14 patients in the event of OPEL 4 status. The bed management team decided to put this part of the plan into action in order to allow patients in the emergency department to be admitted

to a ward. Managers told us patients were selected to be moved to this temporary ward area according to agreed safety criteria. Most were due to be discharged from hospital in the next 24 hours.

- We were later told that discussion about reducing the next day's planned admissions would not take place until the following morning.
- Senior ED staff attended the bed management meeting. They reported that they had not been able to transfer patients to the medical assessment unit (MAU) for the previous two hours. There were currently six patients waiting to be transferred to the MAU. The bed management team decided that extra resources should be deployed to the unit to help with this problem.
- However, by 7pm the ED had still not been able to transfer any patients to the MAU. There were now 12 patients waiting to go there. We asked the hospital site manager why the extra resources had not helped the situation. We were told a consultant physician had been needed to decide which patients could go home and which needed to be transferred to specialist wards. It had taken longer than expected to find the consultant and so no patients had yet been moved out of the unit. The site manger had not been told why the consultant had not been available earlier in the day.

Are urgent and emergency services well-led?

As this was a focused inspection we have not inspected the whole of this key question. Therefore, there is no rating.

Vision and strategy for this service

- The leadership team were united in their aim to improve patient flow through the department. By reducing crowding in the department, they hoped to improve patient safety, the quality of treatment and staff satisfaction. They recognised there needed to be enhanced co-operation with other hospital teams to achieve this aim.
- The team wanted to make the service more patient centred and had created the concept of a "Hot Floor". This consisted of the emergency department (ED), the clinical decision unit, the medical assessment unit and the acute assessment unit (Ambulatory Emergency Care, Frailty Service, urgent treatment clinics and GP-led primary care). In order to bring these services together a Hot Floor Board had been formed, and was led by the lead clinician for ED.

Leadership of service

- The emergency department had a well-motivated leadership team. This consisted of the lead clinician, matron and two associate managers. Staff told us they trusted the leadership team and knew they would be listened to if they raised concerns. They thought leaders had the skills, knowledge, integrity and experience needed for their roles.
- Day-to-day leadership of the department was provided by the emergency physician in charge and the nurse-in-charge. They both had an overview of all patients in the department. We observed them supporting junior staff, leading the treatment of the sickest patients and dealing with the more complex situations that arose
- The clinical lead reported consistent support from the trust's chief operating officer and chief executive. For example, they had led an initiative to reduce the number of delayed patient discharges from the hospital. This had helped to increase the number of beds available on the wards for emergency patients.

Governance, risk management and quality measurement

- There was a well-structured clinical governance system in place with the production of information about the department's clinical quality performance. This was discussed at monthly governance and safety meetings and used to demonstrate effectiveness and progress. Items such as quality indicators, risks, incidents, lessons learnt, complaints, compliments and clinical audits were discussed.
- A safety newsletter was produced every two weeks to highlight clinical safety successes and problems. Plans to address any problems were described so staff were aware when clinical practice needed to change.

- We were told a consultant reviewed all deaths in the department and monthly mortality and morbidity meetings were held. Any issues arising were discussed during governance and safety meetings.
- Senior staff were aware of the risks in the emergency department and these were described on a risk register. The highest risk was a crowded department. It had been recognised many things contributed to this and so a separate 'crowding' risk register had been created. One of the consultants had responsibility for the risk registers. However, they were not present in the department when we inspected and so we were not able see the registers.
- We could not be certain operational performance was regularly monitored or how any weaknesses were addressed. Although the leadership team had an awareness of operational performance issues such as delays for triage and admission, the time taken during the handover of ambulance patients and the speed of urgent brain scans, they did not appear to be regularly monitored. We were told performance meetings were held but no minutes could be found during our inspection. Minutes of the most recent Hot Floor Board meeting (April 2019) stated performance metrics needed to be agreed.

Culture within the service

- There was a supportive and friendly culture within the department which was centred on the needs of patients. Staff formed a close-knit team who took pride in the care and treatment they gave to their patients.
- Attention to staff development was a feature of the department. Senior medical and nursing staff had specific responsibility for teaching and skills development and devoted a lot of time to it. This was appreciated by the staff we spoke with.
- There was a well-established wellbeing programme. This included a welcome pack for new staff and a champion of the week who was nominated by ED but did not necessarily need to be an ED employee. There were "away-day weekends", informal outings, and events were organised to support the ED charity of the year. The department had a private social media group as well as a page for learning. The wellbeing programme also included links to other activities such as yoga, walking and many other fitness, social and health groups. The programme featured strongly in feedback from the junior doctors we spoke with. They regarded it as an important aspect of working in the ED where the working life was invariably pressured.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

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- Reduce crowding in the emergency department so patients do not have to wait on trolley in unsuitable environments.
- Complete initial assessment (triage) of self-presenting patients in a timely fashion and in accordance with standards set by royal colleges.
- Accurately record first clinical observations made by emergency department staff.

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

- Improve and monitor the speed of response from senior specialist doctors when patients have been referred to them by the emergency department.
- Regularly monitor operational performance in the emergency department at a senior level and record issues, including how these are being addressed.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.** 12(1) Care and treatment must be provided in a safe way for service users. Patients' clinical conditions were not always risk assessed in a timely fashion. For example, self-presenting patients were not triaged in line with national guidance when they arrived in the emergency department. Crowding in the emergency department meant patients had to wait on trolleys or beds in unsuitable environments.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good Governance.** 17(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements of this Part. When ambulance patients arrived, emergency department staff recorded the last set of vital sign observations made by the ambulance service. However, on the patient's record, it was unclear when the observations had been taken, or by whom.

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Requirement notices

Therefore, it appeared the observations had been recorded during the initial assessment on arrival at the emergency department. This was misleading and there was a risk it could lead to a delay in further observations of vital signs.