PAPER C

Isle of Wight NHS trust

St Marys Hospital

Quality Report

St Mary's Hospital
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Date of inspection visit: 21 January 2019
Date of publication: This is auto-populated when the report is published

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Isle of Wight NHS Trust provides all acute health services to a population of approximately 140,000 people living on the Island. There is a significant increase in population during holiday and festival seasons. St Mary's Hospital in Newport is the trust's main base for delivering acute services for the island's population.

We carried out an unannounced focused inspection of the emergency department at St. Mary's Hospital on 21 January 2019. The purpose of the inspection was to review the safety of the emergency department as part of a focused winter inspection programme. At the time of our inspection the department was under adverse operational pressure.

We did not inspect any other core service or wards at this hospital or any other locations provided by Isle of Wight NHS Trust. We did visit the urgent care centre, the ambulatory emergency care unit and the acute medical unit. 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 (ED), located at St Mary's Hospital in Newport. It provides a 24-hour, seven day a week service. It is a designated trauma unit but patients with multiple trauma are usually flown directly to the major trauma centre in Southampton.

The ED consists of a major treatment area with 10 cubicles, a minor treatment area with three cubicles, resuscitation room with three trolley bays and a new rapid assessment and treatment area. Children have a separate waiting room and are treated in three rooms adjacent to the major treatment area. There are separate rooms for mental health assessment, eye examinations and application of plaster casts. Adjacent to the emergency department is a newly formed urgent care centre for the treatment of patients with minor illnesses and injuries.

Our key findings were as follows,

- Despite recent recruitment of additional band seven nurses there remained a significant shortage of qualified nurses. In the month prior to our inspection there was heavy reliance on agency nurses. Although agency nurses are fully qualified they do not always have the specialist experience needed in ED and have sometimes not worked in the department before.
- Staffing information displayed in the department during our inspection showed that eight nurses were expected to be on duty but only six were present. As a result, the nurse in charge was having to assess newly arrived ambulance patients, look after patients requiring care in the corridor, assist in the resuscitation room, take over from nurses on meal breaks as well as co-ordinate the care of all the patients in the department. It was not possible for one nurse to do all of this and we found several aspects of patient care had not been completed.
- There were periods of time during the evening when there were no nurses in the major treatment area, the minor treatment area or the rapid assessment area.
- Although a formal review of nursing levels was undertaken in September 2018, it was not clear whether the increase in nursing numbers would be implemented.
- Initial assessment (triage) of ambulance patients did not take place according to guidance produced by the Royal College of Emergency Medicine and the Royal College of Nursing. Although a handover generally took place within 15 minutes of arrival, there was no face-to-face assessment of these patients by an experienced nurse. Subsequent observations and assessments were often undertaken by a healthcare assistant.
- The department was crowded throughout our inspection with patients receiving care and treatment (such as intravenous infusions) in corridors.When we arrived, one patient had been in the department for 15 hours. The patient had been nursed in the corridor for three hours.

Summary of findings

- During the evening there was no nurse in the rapid assessment and treatment area for 30 minutes. This meant that newly arrived ambulance patients (up to four at any one time) were being assessed by a healthcare assistant.
- During a review of the records of patients in the major treatment area we found that four out of six patient safety checklists were incomplete.

However,

- Almost all staff spoke positively about working in the emergency department.
- There had been improvements in patient flow since new processes for GP referred patients had been implemented.
- All critically ill patients were seen quickly by a senior emergency department doctor and were treated according to national guidance.
- Junior doctors felt well supported and were positive about the training they received in the emergency department.
- The new role of patient flow co-ordinator helped to ensure that patients waiting for specialist assessment or to be admitted to a ward were not forgotten.

Professor Edward Baker
Chief Inspector of Hospitals

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 at St. Mary's Hospital on 21 January 2019. The purpose of the inspection was to review the safety of the emergency department as part of a focussed winter inspection programme. At the time of our inspection the department was under adverse operational pressure. We did not inspect any other core service or wards at this hospital or any other locations provided by Isle of Wight NHS Trust. We did visit the urgent care centre, the ambulatory emergency care unit and the acute medical unit. During this inspection we inspected using our focused inspection methodology. We did not cover all key lines of enquiry. We did not rate this service at this inspection.

St Marys Hospital

Detailed findings

Services we looked at
Urgent and emergency services

Detailed findings

Contents

Background to St Marys Hospital

The emergency department (ED) at St Mary's Hospital provides a 24-hour, seven day a week service. It is a designated trauma unit but patients with multiple trauma are usually flown directly to the major trauma centre in Southampton. It sees approximately 49,000 patients a year.

The ED consists of a major treatment area with 10 cubicles, a minor treatment area with three cubicles, resuscitation room with three trolley bays and a new rapid assessment and treatment area. Children have a separate waiting room and are treated in three rooms adjacent to the major treatment area. There are separate rooms for mental health assessment, eye examinations and application of plaster casts. Adjacent to the emergency department is a newly formed urgent care centre for the treatment of patients with minor illnesses and injuries.

We last inspected the emergency department in January 2018. Following that inspection, the ED was rated inadequate with breaches in regulations 12 Safety, 17 Good governance and 18 Staffing. Requirement notices were issued at that time.

Our inspection team

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

The inspection was overseen by Bernadette Hanney, Head of Hospital Inspection.

How we carried out this inspection

We carried out an unannounced focused inspection of the emergency department at St. Mary's Hospital on 21 January 2019. The purpose of the inspection was to review the safety of the emergency department as part of a focussed winter inspection programme. At the time of our inspection the department was under adverse operational pressure. We spoke with spoke with eight patients, one relative and eighteen members of staff.

We did not inspect any other core service or wards at this hospital or any other locations provided by Isle of Wight NHS Trust. We did visit the urgent care centre, the ambulatory emergency care unit and the acute medical unit. 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.

Urgent and emergency services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

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Summary of findings

- Despite recent recruitment of additional band seven nurses there remained a significant shortage of qualified nurses. In the month prior to our inspection there was heavy reliance on agency nurses. Although agency nurses are fully qualified they do not always have the specialist experience needed in ED and have sometimes not worked in the department before.
- Staffing information displayed in the department during our inspection showed that eight nurses were expected to be on duty but only six were present. As a result the nurse in charge was having to assess newly arrived ambulance patients, look after patients requiring care in the corridor, assist in the resuscitation room, take over from nurses on meal breaks as well as co-ordinate the care of all the patients in the department. It was not possible for one nurse to do all of this and we found several aspects of patient care had not been completed.
- There were periods of time during the evening when there were no nurses in the major treatment area, the minor treatment area or the rapid assessment area.
- Although a formal review of nursing levels was undertaken in September 2018, it was not clear whether the increase in nursing numbers would be implemented.
- Initial assessment (triage) of ambulance patients did not take place according to guidance produced by the Royal College of Emergency Medicine and the Royal College of Nursing. Although a handover

Urgent and emergency services

generally took place within 15 minutes of arrival, there was no face-to-face assessment of these patients by an experienced nurse. Subsequent observations and assessments were often undertaken by a healthcare assistant.

- The department was crowded throughout our inspection with patients receiving care and treatment (such as intravenous infusions) in corridors. When we arrived, one patient had been in the department for 15 hours. The patient had been nursed in the corridor for three hours.
- During the evening there was no nurse in the rapid assessment and treatment area for 30 minutes. This meant that newly arrived ambulance patients (up to four at any one time) were being assessed by a healthcare assistant.
- During a review of the records of patients in the major treatment area we found that four out of six patient safety checklists were incomplete.

However,

- Almost all staff spoke positively about working in the emergency department.
- There had been improvements in patient flow since new processes for GP referred patients had been implemented.
- All critically ill patients were seen quickly by a senior emergency department doctor and were treated according to national guidance.
- Junior doctors felt well supported and were positive about the training they received in the emergency department.
- The new role of patient flow co-ordinator helped to ensure that patients waiting for specialist assessment or to be admitted to a ward were not forgotten.

Are urgent and emergency services safe?

Environment and equipment

- The emergency department (ED) was designed to allow staff to have audio or visual awareness of as many patients as possible. There was a central staff base surrounded by a major treatment area with 10 cubicles, a minor treatment area with three cubicles, a resuscitation room with three trolley bays (including one for children) and a rapid assessment and treatment area for the assessment of patients brought to the department by ambulance. Children had a separate waiting room and were treated in three rooms adjacent to the major treatment area.
- Due to poor patient flow through the department patients had to be treated and cared for in the central corridor running through the middle of the major treatment area. One patient described it as “Like sitting in a goldfish bowl” as the corridor was in a main thoroughfare and provided no rest or privacy. The patient was waiting for transport to take them home and spent two hours sitting in the corridor on a hard chair which had no arms to provide support.
- Another patient on a chair was being treated with intravenous infusions. Other patients were lying on beds or trolleys while waiting to be admitted to a ward. The number of patients in the corridor varied from two to six patients throughout our inspection.
- A new urgent treatment area had been developed in part of the adjacent out-patients’ department. It consisted of three large consulting/examination rooms designed for the treatment of patients with minor injuries and illnesses.
- There was a designated room for seeing patients who required a mental health assessment. This had recently been modernised so that it met the Psychiatric Liaison Accreditation Network quality standard requirements.
- The department had a dedicated ambulance entrance, which was located near to the major treatment and resuscitation areas. A helicopter landing pad was situated close to the ED to enable air ambulances to land.
- An adjacent imaging department provided X-rays and scans for walking patients and those on trolleys.

- 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 that it was ready for use.

Assessing and responding to patient risk

- Initial assessment (triage) of ambulance patients did not take place according to guidance produced by the Royal College of Emergency Medicine and the Royal College of Nursing.

The guidance states that "Triage is a face-to-face contact with the patient" and that it should be carried out by a qualified healthcare professional who has had specific training. This assessment was required to determine the seriousness of the patient's condition and to make immediate plans for their on-going care. Although triage was carried out within 15 minutes by ED nurses who had been trained, there was no face-to-face contact with patients. Instead, for much of our inspection, the triage nurse sat down with a member of the ambulance crew and entered information on to a computer. Based on this information a triage priority was decided and entered into the computer record. Sometimes the patient was at one end of the department and the triage nurse was using a computer at the other end of the department. There was no attempt to confirm information with the patient or to assess their current condition by, for example, checking a pulse or breathing rate.

- The ambulance crew then took the patient to the rapid assessment and treatment area (often known as "the pitstop") This was frequently staffed by a less experienced band 5 nurse assisted by a healthcare or emergency department assistant. During our inspection the emergency department assistant was left on her own for 30 minutes as the qualified nurse needed to take a meal break. The emergency department assistant was assessing up to four patients at any one time during that period.
- Staff in the pitstop told us they rarely received a detailed handover from the ambulance crew because all the information had been given to the nurse-in-charge. This made it difficult for them to carry out a full assessment of the patient.
- We saw very few delays in the handover of patients from ambulance crews to ED staff. However, data provided by the trust showed that three patients had experienced a delay of more than an hour since the beginning of December 2018.
- Triage of patients who did not arrive by ambulance varied in quality. During the afternoon we observed that it was methodical and thorough and took place within 15 minutes of arrival. However, by 6.15pm all patients were waiting for longer than 20 minutes to be triaged. Plans for on-going care did not always seem to be in the patient's best interests. For example, we observed one patient lying across the seats in the waiting room in obvious pain. Although pain relief had been offered no arrangements had been made to take the patient to a treatment area so that they could be more comfortable. We observed another patient who had been assessed as having a minor illness. They became increasingly uncomfortable and tearful during the hour that we observed them. We drew this to the attention of the nurse in charge. She discovered that the patient had been diagnosed with kidney stones and immediately moved them to the rapid assessment and treatment area.
- The department had recently introduced a new role of a "streaming" nurse who would quickly assess patients as soon as they arrived. These experienced nurses would be able to redirect those patients who could be treated more effectively in primary care settings or in the ambulatory emergency unit. Unfortunately, due to staff shortages, no streaming nurse was present during our inspection.
- 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 looked at the records of 14 patients in the major treatment area (including the corridor). All had had an early warning score calculated when they arrived and at regular intervals during their stay in the department.
- Nurses in the department used a patient safety checklist. This was aimed at reminding nursing staff to undertake hourly safety checks of all patients in the major treatment area. However, some patients had not

had the safety checks applied. We looked at the safety checklists of six patients who had been in the department for between two and 15 hours. Only two of them had been fully completed.
- There were monthly audits of patients records which showed that the quality of nurses' record keeping was improving. However, it was not clear whether the patient safety checklist was included in the audits.
- A risk assessment was carried out before patients were placed in the corridor. All of them had been examined by a doctor and test results and observations had shown that their condition was stable.

Nursing staffing

- Despite recent recruitment of additional band seven nurses there remained a significant shortage of qualified nurses and a heavy reliance on agency (temporary) nurses.
- We looked at nurse staffing levels for 20 random shifts over the last three months (starting on 1 October 2018). Eight of the 20 shifts had 40%-50% of agency nurses. All the shifts had at least one agency nurse. Although agency nurses are fully qualified they do not always have the specialist experience needed in ED and have sometimes not worked in the department before. This means that some patients were not looked after by nurses with the experience required.
- The matron told us that the agency nurses currently in the department had been employed for a number of months and were familiar with local working practices. However, there had been some short-term agency nurses in recent months.
- Registered nurses were support by healthcare assistants and senior healthcare assistants known as emergency department assistants.
- Staffing information displayed in the department during our inspection showed that eight registered nurses were expected to be on duty but only six were present. There were no additional registered nurses in the hospital to assist. As a result, the emergency department matron had extended her working hours for the day so that she could look after patients in the resuscitation room.
- Despite this, the nurse in charge was having to assess newly arrived ambulance patients, look after patients requiring care in the corridor, assist in the resuscitation room, take over from nurses on meal breaks as well as co-ordinate the care of all the patients in the department. It was not possible for one nurse to do all of this and we found several aspects of patient care had not been completed.
- We observed that the nurse in charge was often called away from the staff base, for example to check intravenous medicines or receive ambulance patients. When this happened, it was easy to lose track of patients. We observed a nurse returning to the major treatment area and asking what had happened to the patient in cubicle 10. The cubicle was empty and no-one knew where the patient was. It took two nurses 10 minutes to discover that the patient was safe.
- During the evening an elderly patient in the major treatment area called out to a CQC inspector because she needed to use a commode but there was no nurse to help her. While the inspector was trying to find a nurse a second patient was seen trying to climb off the end of their trolley for the same reason. There was no nurse present and so the inspector and a junior doctor started to help the second patient on to a commode. After five to ten minutes the emergency department matron arrived and completed the assistance required by the patients. We were later told that the nurse who was meant to be in the major treatment area had been called away to help administer urgent medication to a patient in another part of the department.
- One frail patient required transport to take them home after treatment. Due to the shortage of nurses, information about transport requirements was not communicated to the nurse in charge. As a result, transport was not order for two hours after it was required.
- The pitstop area had no qualified nurse present for 30 minutes during the evening. An emergency department assistant was trying to assess ambulance arrivals unaided.
- A formal review of nursing levels had taken place in September 2018 and we were shown part of the summary. It indicated that 44 qualified nurses were needed in the department, as opposed to 33 currently employed. Although a business case for more nurses had been submitted to the trust board, it was not clear whether all the additional nurses were included.
- The department had been successful in recruiting registered children's nurses. There were now four employed in the department meaning that one was looking after children for most of the time. Most adult

nurses had received further training in the assessment and care of sick children in an emergency setting. They had been assessed as competent by the department's lead children's nurse.

- There were good levels of resuscitation training amongst nursing staff. We were shown records demonstrating that 31 of 33 nurses had adult, children's and trauma immediate life support qualification. Six nurses had advanced resuscitation qualifications and one band seven charge nurse was a Resuscitation Council instructor.
- There was a good skill mix in the department with 13 band five nurses, 10 more experienced band 6 nurses and six senior band 7 nurses. This was a significant improvement to our last inspection when there was only one band seven nurse.
- In addition, there were two emergency nurse practitioners who treated patients with minor injuries. Three nurses were currently being trained to become emergency nurse practitioners. An emergency care practitioner commenced work the week before our inspection and would be treating patients with minor illnesses.

Medical staffing

- The medical team were led by four permanent consultants, one locum (temporary) consultant and an associate specialist. The permanent consultants were included in the specialist register of the General Medical Council. The rota allowed one consultant to be in the department from 8am to 8pm on week days and 8am to 4pm at the weekends. This was less than the 16 hours a day recommended by the Royal College of Emergency Medicine. We noted that the permanent consultants usually worked the 8am-4pm shifts which could mean that they had a reduced awareness of issues that arose during the evenings.
- We looked at the rota for the month before our inspection and saw that, when there were no consultants in the department, there was always a senior middle grade (ST4 or above) on duty. There was a consultant on-call from home at night.
- There had been a recent increase in junior doctors so that the middle grade doctor was supported by two junior doctors at night. Staff told us that this had improved safety and speed of response during the night.
- All junior doctors spoke positively about working in the ED. They told us that the consultants were supportive and accessible. In-house teaching took place twice a week and was comprehensive and well organised.
- Most doctors told us that they were able to take meal breaks and usually finished their shifts on time. One doctor told us that current shift patterns did not always allow an 11-hour break between the end of one shift and the start of another. The matter had been raised at a staff meeting and there were plans to re-arrange the rota to allow for sufficient rest.
- The department had started to introduce multi-disciplinary handovers (sometimes known as a safety huddle) at 8am and 8pm when nursing teams changed over. We observed one that took place at 8pm which was attended by an ED consultant, the nurse in charge for the night shift, the ED matron and a junior doctor. The handover was led by the matron. Items handed over were the safety status of the department, medical and nursing staffing levels, nutrition and hydration of patients, the bed capacity of the hospital and how many beds were available for emergency admissions. There was also a reminder to all staff that the nurse or doctor in charge of the department should be informed of any patients with an early warning score of five or more. It should be noted that the consultant who took part was in addition to the normal consultant staffing levels. Due to clinical responsibilities we could not be certain that there would always be a consultant available to take part.

Major incident awareness and training

- We found a copy of the major incident plan in the resuscitation room. However, it had been due for review in October 2018. It was not clear who was responsible for updating it. It did not include any action cards for individual members of staff so that they were aware of their role in an unexpected emergency.
- Equipment and protective clothing for staff when dealing with chemical, biological, radiological and nuclear incidents was stored in an easily accessible cupboard. Records showed that staff had been trained in its use.

Are urgent and emergency services effective?

Urgent and emergency services

(for example, treatment is effective)

Are urgent and emergency services caring?

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. 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 hospital 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.
- Senior ED staff reported good working relationships with senior managers responsible for patient flow within the hospital. Hospital managers came to the department before bed management meetings in order to understand the number of emergency admissions that would be needed in the next few hours. However, they did not appear to consider the number of ambulance that were on the way to the hospital and were likely to result in additional admissions.
- ED staff were clear about the situations that they needed to escalate to hospital managers. They told us that they always received a sympathetic response although hospital managers were rarely able to prevent a crowded emergency department with patients being cared for in unsuitable environments.
- 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 five emergency department patients in a corridor waiting to be admitted to a ward. Two had been in the department for 15 hours.
- There had been an improvement in patient flow through the department in recent weeks. At the beginning of December 2018 new arrangements had been made for emergency medical patients referred to the hospital by their own GP. Instead of being treated in the emergency department they now went straight to the acute medical unit to be seen by specialist doctors.
- This had resulted in an improvement in the number of patients spending less than four hours in the emergency department. (A standard set for all hospitals in England). Before the changes for GP referred patients only 67% of patients spent less than four hours in the department (November 2018). This compared poorly to other hospitals in England where the average was 81% of patients. For the first three weeks in January 2019 the number of patients spending less than four hours in the department had increased to 82%
- Despite these improvements staff told us that bed availability was still a problem, particularly at night. By 9.30pm we saw that four patients needing to be admitted to a ward and were told that only two beds were available. Since there were no planned discharges overnight it was unlikely that any more beds would become available. Any further patients needing admission during the night would need to stay in the emergency department.
- Nurses told us that when they arrived at the start of the day shift, the major treatment area was often full of patients awaiting admission. Identifying a nurse to make breakfast for everyone that needed it could sometimes be difficult.
- The operations manager told us that an "escalation" ward had been opened in November as part of the hospital's winter plan. It was designed to accommodate additional medical patients who often needed to be admitted during the winter. It was not completely occupied during our inspection. Six beds were empty but would be opened if crowding in the ED became worse. For example, if there was no space in the department for ambulance crews to handover their patients.
- There were sometimes delays when patients were referred to specialist doctors. It was difficult for staff to keep track of these delays as specialty doctors did not

use the ED computer system and so the time that they saw a patient was not always recorded. To improve this situation a new role of patient flow co-ordinator had been created. The co-ordinator was informed when a patient had been referred to specialist by nursing and medical staff. They then monitored the progress of the patient, including when test results were received. If delays occurred the co-ordinator would investigate the reasons and report them to the nurse or doctor in charge.

- However, the co-ordinator role had only been in place for a week and so delays still occurred. A patient with breathing difficulties waited for two hours for specialist physician. A patient with a throat problem waited for over four hours to see a surgeon.
- Senior doctors in the emergency department were able to make a decision to admit if specialty doctors were delayed. This allowed the bed management team to start planning for admission at the earliest opportunity.
- An ambulatory emergency unit had been created in part of the acute medical unit. It was aimed at providing rapid, day case treatment for emergency patients. However, it was also used to provide beds for emergency admissions overnight. It could take several hours to transfer the overnight patients which meant that it was not always available for ambulatory patients. On the day of our inspection it had taken until 1pm for it to be ready to be used for ambulatory treatment. As a result, ambulatory patients either had to be admitted to a ward or had to wait in the emergency department. This further added to the crowding in the department.
- The hospital had a multi-disciplinary frailty team who assessed and treated frail patients who did not have a severe illness. Their aim was safe early discharge of these patient. The team was at an early stage of development and was only able to treat patients once they had been admitted to the hospital. It was hoped that, in the future, they would be able to assess patients as soon as they arrived in the ED in order to avoid unnecessary admissions.
- There was a large electronic screen by the staff base which displayed a patient flow dashboard in real time. At 6.48pm it showed that there were 45 patients in the department and that 83% had been admitted or discharged within four hours. Ten patients required admission and were waiting for beds to become available. The longest delay for admission at the time was five hours and 53 minutes. The longest wait for a bed during the last 24 hours was 11 hours and 16 minutes.

Are urgent and emergency services well-led?

Vision and strategy for this service

- A new approach was being taken to developing the vision and strategy for the service. This was due to the implementation of a new management structure with new directors and a different approach to agreeing a strategy. Senior ED staff told us that this had brought new energy to planning for the future.
- Senior staff had a shared vision for the service which included the development of the urgent care centre, ambulatory emergency care unit and a frailty team within the emergency department.

Leadership of service

- The department was part of new care group within the hospital. It consisted of the emergency department, the acute medical unit, ambulatory emergency care unit and the ambulance service. Although the care group was in its infancy ED staff thought that it was well designed and would help to improve the effectiveness of the department.
- The emergency department leadership team was led by a clinical director, a senior consultant who had been in post for several years. This provided stability to the team. The clinical director was joined by a matron and an operations manager. The matron role was currently filled on an interim basis. However, the post holder had been in post since May 2018 and took an active part in clinical management.
- The leadership team appeared energetic, cohesive and well-motivated. They were highly visible in the clinical environment, supporting junior staff, leading the treatment of the sickest patients and dealing with the more complex situations that arose.
- We were told that a member of the trust board would visit the emergency department at about 10am each day during the week. They sometimes provided an insight into patterns of activity. For example, the

finance director had noticed that emergency admissions to the acute medical unit often happened in "batches". Further work was taking place to discover the cause of this and to try and make admission processes smoother.

Governance, risk management and quality measurement

- Senior staff described comprehensive clinical governance processes. We were shown minutes of monthly ED quality meetings which were well attended by the multi-disciplinary team. They included discussion of new clinical guidance, incidents, patient feedback, the risk register and clinical audit.
- We were told that a consultant reviewed all deaths in the department and that monthly mortality and morbidity meetings were held. Although there were no records of these we saw that any issues arising were mentioned during quality meetings.
- We found the quality of clinical guidance available to nursing and medical staff was variable. For example, written guidance for the treatment of serious heart conditions was haphazard and some of it was out-of-date. When we tried to find clinical guidance on the hospital intranet we could find little relevant information for the treatment of trauma, atrial fibrillation or stroke. However, guidance for serious diabetic conditions were current and comprehensive.
- The matron had introduced a new process to improve patient awareness by the nurse and doctor in charge of the department during the day. Known as safety rounds, the process was designed to involve two senior nurses and a consultant. They would review the plan of each patient in the resuscitation room, major treatment area and corridor to ensure that observations were up-to-date and address any delays in the patient's progress. The safety rounds were meant take place every two hours.
- We observed a safety round taking place during the evening. Due to a shortage of staff it was undertaken by the matron and head of nursing of the care group. There were no senior doctors available. The safety round identified that pressure area care and clinical observations had been delayed. The matron arranged for a healthcare assistant to be redeployed to assist with these aspects of care.
- Nurses told us that it was not unusual for safety rounds to be delayed because of a shortage of staff. We found that one patient, who had been in the department for 15 hours, had only been included in two safety rounds. However, the patient had experienced few delays in clinical observations or other acute care.
- The operations manager had a good understanding of performance issues such as ambulance handover times, bed availability and response times from in-patient teams. However, operational performance had only been discussed at one departmental meeting in the last three months. It was not clear how issues such as referral delays and long waits for admission were being monitored or addressed. For example, no-one could tell us whether all patients requiring an urgent brain scan were scanning within one hour. The trust has been inconsistent in submitting any national data for time to initial clinical assessment, and from June to the end of the year submitted data that showed a median of 0 minutes for ambulance patients. We observed these assessments taking between two and 18 minutes.
- We saw that there were good working relationships with the acute medical team and the radiology department. We observed that communication with surgical teams was difficult and some of the longest waits for a specialist opinion were for surgical teams. Senior staff described collaborative working relationships with the senior manager for the day and the executive director on call.

Culture within the service

- Several staff told us that morale had improved in recent months and that they enjoyed working in the emergency department.They told us that senior staff had become more visible and approachable. They would feel happy to confide in them if they had concerns about working in the department.
- Some nurses described working at night as "depressing". This was because it was very difficult to admit patients to a ward at night and sick patients had

to stay in a noisy emergency department where it was difficult to sleep or rest. Nurses found themselves constantly apologising to patients and their families about the situation.

- We observed easy, effective and courteous communication between all grades and disciplines of staff within the department.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- There are sufficient numbers of suitably qualified, competent, skilled and experienced nurses to meet the needs of patients in the Emergency Department (ED). Regulation 18(1)
- Crowding is reduced so that patients do not have to wait on trolleys in the corridor in the major treatment area. Regulation 12(2)(b)
- Patients whose clinical condition is at risk of deteriorating are rapidly identified and monitored appropriately. Regulation 12(2)(a)(b)

Action the hospital SHOULD take to improve

- Patient safety checklists are fully completed.

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
Patients were cared for and treated in non-designated areas for clinical care in the emergency and accident department. **Patients were not always assessed in a timely or safe manner, or assessed by staff who were suitably qualified.** **There were insufficient numbers of staff on duty to deliver safe care and treatment to patients.**	Urgent and emergency services.