

Portsmouth Hospitals NHS Trust

Queen Alexandra Hospital

Quality Report

Queen Alexandra Hospital
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Date of inspection visit: 22 and 23 February 2016,
and 3 and 4 March 2016.
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

Overall rating for this hospital

Inadequate



Urgent and emergency services

Inadequate



Medical care (including older people's care)

Requires improvement



Summary of findings

Letter from the Chief Inspector of Hospitals

Queen Alexandra Hospital is the acute district general hospital of the Portsmouth Hospitals NHS Trust. It is the amalgamation of three previous district general hospitals, re-commissioned into a Private Finance Initiative (PFI) in 2009. The hospital has approximately 1,250 inpatient beds, and has over 137,000 emergency attendances each year.

We undertook a comprehensive inspection of Portsmouth Hospital NHS Trust last year, in February and March 2015. At that time we found some patients in the emergency department (ED) were at risk of unsafe care and treatment. We rated the safety of urgent and emergency care services as 'inadequate'. We served two warning notices on 4 March 2015, under safety for "care and welfare of patients" and "assessing and monitoring the quality of service provision" in the emergency department. These required the trust to make immediate action to improve the initial assessment of patients, the safe delivery of care and treatment, and the management of emergency care in the ED. A subsequent re-inspection of the emergency department in April 2015 saw improvements, and the service was then rated overall as 'requires improvement'.

Prior to this inspection, we had received information of concern about the trust's performance with its emergency pathway from the trust, NHS England, the Trust Development Authority and the Emergency Care Improvement Programme (ECIP). There had been two risk summits held on 14 December 2015 and 28 January 2016, which had identified the following significant areas of risk.

- The trust performance against the four hour national emergency access target was one of the lowest in the county (in January 2016 it was 68.8%; national average was 83%).
- The emergency department (ED) was overcrowded and patients were not being assessed and treated in a timely way. Significant areas of risk identified delays in initial 15 minute assessments and patients for Medical Assessment Unit (MAU) were being held in a queue instead of immediate access
- Escalation procedures had not been appropriately followed and sometimes the trust had reacted too late to pressures.
- A 'Jumbulance' was being used to assess and treat patients because of ongoing over-capacity in the ED.
- Medical teams did not have general medical beds for admission. Whilst there is a named physician within AMU, it was not always clear who was the admitting consultant responsible for the patient
- The hospital reported between 90 to 150 medically fit patients awaiting discharge. This number reduced to 50 patients when delays over 24 hours were removed. Some were simple discharge delays and some were delayed transfer of care.
- The trust's failure to manage emergency admissions was impacting on partners. South Central Ambulance Service had queuing ambulances. Their reduced fleet had meant they were not meeting response times. There had been two serious incidents where response times for life threatening conditions had not been met, this included a road traffic accident on the M27 where a tent had to be erected whilst waiting for an ambulance.
- Solent NHS Trust was using escalation beds and community, GP and local authority teams have said that some patients were being discharged inappropriately.
- Southampton General Hospital had to take patients diverted from Portsmouth when the hospital itself was under pressure with emergency admissions.
- The trust had experience an increased number of emergency attendances in 2015/16 (month 10) when compared to the previous year (2014/15). There had been an increase of 4.6% attendances which equated to an extra 11 patients per day. This was higher than the national average at 1% increase. Overall, when GP heralded and urgent care centre

Summary of findings

patients were included the increase was 7.3% which equated to an extra 20 patients per day. This presented significant pressure on the ED. However, the trust had yet to ensure appropriate use of the Urgent Care Centre. GP heralded patients went direct to ED rather than directly to MAU and this was added to the overcrowding in the emergency department.

- The conversion rate of patient attendance to admission was 35.5%. Delayed transfers of care were at 1.9% which was significantly lower than national levels (2.5%). Comparatively, the trust was admitting more patients for assessment, although the case mix of patients needed further review. There was however, a delay in introducing admission avoidance models of care and in ensuring coordinated hospital action to improve patient flow.

Following the first risk summit, the trust was given a number of actions. These were reiterated at the second risk summit due to a lack of initial progress, to: introduce Safer Start, a system to accelerate discharge, develop a short stay patient model of care, ensure that expected GP patients went directly to the medical assessment unit, change the medical model for emergency admissions, introduce a frailty interface team, focus on reducing the variation with simple discharge and complex discharges and introduce 'discharge to assess'. The trust was also required to work with the Emergency Care improvement Programme (ECIP) and ensure their recommendations were implemented

On 22 and 23 February and 3 and 4 March, 2016, we undertook an unannounced and focused inspections of the emergency care pathway at Queen Alexandra Hospital. The focus of our unannounced inspection was on the actions taken by the trust in response to the identified risks to patients through their emergency care pathway. We inspected two core services: urgent and emergency care and medical services.

We reviewed the service based on our five key questions: is the service safe, effective, caring, responsive and well-led?

Our key findings were as follows:

- The trust was failing to ensure emergency patients received safe care and treatment and the emergency service was struggling to respond to the needs of patients. The trust leadership had failed to make significant, urgent and necessary changes to improve the flow of emergency patients through the hospital. The risks to patients was unacceptable; the pressure and environment under which staff were working was unacceptable.
- Patients were not being triaged, assessed and treated within the emergency department in a timely manner. The 15 minute standard to assess patients was not being met. During the inspection time period, we observed only some patients, including patients with serious conditions, being assessed with 15 minute. Trust data was in averages but additional data available from the Trust covering the four days of the inspection demonstrated that only 65% of ambulance patients were assessed within 15 minutes and approximately 87% were assessed within 30 minutes. For patients with a serious condition, such as sepsis, chest pain or fractured neck of femur, trust data demonstrated that only 57% were triaged with 15 minutes (11% waited over 30 minutes). 35% were treated within 1 and 34% waited over two hours for treatment.
- Due to poor flow through the department, there were often several ambulances queuing outside the department. On 22 February there had been 16 vehicles queuing at 19:00. On 23 February, there had been 16 ambulances queuing outside of the trust by 16:00 and overnight. The Jumbulance was re-opened and was being used to manage the ambulance waits.
- On 22 February, South Central Ambulance Service (SCAS) recorded there was a total of 93 hours of excess handover time, and a further 84 hours the following day. The average handover time across those two days was 61.5 minutes. The 16 ambulances represented one third of the South East Hampshire ambulance fleet were being held at Queen Alexandra Hospital. The ambulance stacking had meant there have been capacity issues for the ambulance service, that have had to hold eleven 999 emergency calls due to no emergency ambulances being available locally for dispatch.
- There was a significant risk of harm to patients being held, assessed or treated outside the ED, within an ambulance or "Jumbulance". There was no single accountable lead for the decision about which patients should be brought into

Summary of findings

the department, when there were ambulances held. There was not always a senior decision maker evident. The decision making process was often arbitrary between nurses and ambulance staff. Although there was a process, as agreed by ECIP for the triage of patients. However, as the department became overcrowded we observed that clinical staff did not adopt a standard process to triage and we observed the process to be “chaotic”. Some patients had two clinical staff go to assess them – a consultant and a nurse from the majors areas - and some patients had none.

- We identified patients with serious conditions, such as chest pain, suspected sepsis, fractured neck of femur, and stroke that had not been triaged, assessed and treated in a timely manner. For example, patients with suspected sepsis patients were not always seen or treated within an hour of presentation. Patients with suspected stroke symptoms were not always triaged quickly enough to allow for timely administration of thrombolysis.
- Patients with non-life threatening conditions were waiting long periods of time in an ambulance. Many of these were vulnerable patients. Elderly frail patients were waiting in ambulances for over two hours. One patient with a learning disability had waited in an ambulance for over 2.5 hours. Whilst there is no formal policy describing the accountability arrangements for patients whilst in the back of an ambulance on site, at all times a trained paramedic is with the patient; However, the responsibility to notify Trust staff of any patient deterioration was not clear. There was not a consistent mechanism for ensuring that any deterioration would be detected by staff. During the wait in the vehicle, observations were not consistently recorded. Sometimes, the first observations recorded in the triage process had been recorded by the ambulance staff and were not up to date information.
- There was regular, significant and substantial overcrowding in the emergency department. Patients were waiting on trolleys in the corridors. On 22 and 23 February, the corridor outside the ambulance handover area was being used for up to nine patients. There were instances where initial assessments and minor procedures (such as venesection) occurred in the corridor.
- On 22 and 23 February, the patients in the corridor were being observed and monitored by one nurse. The nurse was also allocated to assess the incoming ambulance patients. She did not have capacity to look after the patients in the corridor queue and in ambulances. The assessment and ongoing care and treatment of patients in the corridor was inconsistent. The privacy and dignity of the patients waiting in the corridor was could not be guaranteed. There were frequent and lengthy period where patients were not being observed by a healthcare professional in the corridor. One agency paramedic was observed in the department at approximately 16.00 on the 23 February. Agency paramedic staff had not been observed in the department from between 8am and 4pm that day when the department had been equally as busy.
- Mental health patients remain in the department in an unsuitable environment for excessive amount of time, for example, one patient waited 23 hours in the majors area.
- On 4 and 5 March the corridor was again being use for up to nine patients by one nurse. There patients in the corridor who were not being observed or monitored and patients waiting in ambulances who had not been assessed after one to two hours. One agency ambulance healthcare support worker and one agency healthcare technician arrived to support at 12.25am on the 5 March. These agency staff had not been observed beforehand. After patients were assessed patients were waiting a long time for treatment. For example, a patient who required oxygen had not been given this for several hours. A diabetic patient with acute kidney injury had a referral letter handed to the receptionist. The letter was scanned on to the computer system by the receptionist and the triage form was ticked to indicate documentation was received from the GP. The patient had not received immediate treatment and we asked the nurse about the patient. The nurse told us that she was not aware of the contents of the letter. The nurse had not looked at the computer system and the letter had not been given to the nurse until three hours after their triage assessment.
- Patients waiting in ambulances and those queuing in the corridor did not always receive compassionate care. For example, there was no means for patients to call for help and staff were not always able to check on the wellbeing of patients. We observed many patients who were confused and in distress.

Summary of findings

- We found that escalation process were not consistently followed. Staff did not respond appropriately to peaks and surges in demand. There was no evidence that patients were being effectively streamed through the department or that beds were being used flexibly, for example, in ‘majors’, to respond to the care and treatment needs for patients. The standard operating procedure for Full Capacity in the Emergency Department (November 2015) or the Management of Majors during Full Capacity (draft 22 February 2016) was not being used to allow flexibility in the way beds and cubicles were used in the emergency department. In February and March, we often observed empty beds in majors and the observation wards when patient had been in an ambulance, in corridors, and in areas without curtains.
- The capacity and flow issues meant that simple processes became very inefficient. For example, blood samples and ECGs test results went missing and were being repeated, this presented delays to patient treatment. There were multiple moves of patients around the department and through the Medical Assessment Unit (MAU), resulting in multiple handovers of care.
- The handover of patients was not sufficiently detailed and there were important and clinically significant details missed. Handover information within the ED and between ED and MAU was either absent or too brief. For example, we observed risk assessment about patient’s condition or a patient risk of absconding, was not provided. Patients were not being effectively streamed through the emergency department. We identified that staff had “lost” patients within the system. For example, on three occasions, on 23 February staff were unable to say where their patient was in the emergency department, or what treatment they required next.
- During our inspection, CQC staff had to intervene to keep patients safe on several occasions, including asking staff to assess patients in the ambulance and the corridor, and to prevent a patient from leaving the department when there was not a member of staff present.
- Patients received inconsistent care and treatment on the MAU. Some patients had risks assessments of their needs but their plans for care were either absent or were not being followed. For example the Sepsis pathway was not followed for one patient. No written care plans for six patients with indwelling urinary catheters were identified, however it is noted that this was recorded on the electronic Vitalpac system. Two patients had grade 2 pressure ulcers without care plans or body maps and for one patient the nursing staff did not know the appropriate dressing to use. The early warning score was not consistently being used to responded to and escalate patients appropriately. Nursing staff were sometimes not competent to care for patients. We observed poor care for a patient with cognitive impairment. We raised our concerns with the senior nurse in charge. Infection control practices were not being followed and there was not always appropriate availability of equipment, for example, cardiac monitors.
- Patient flow was not being managed effectively. There were multiple Patient Flow Nurses from different clinical service centres. The nurses were not communicating effectively with each other to enable effective patient flow through the MAU and the wards. We observed three bed meetings. There was not a collective or cohesive process to identify capacity across the hospital. There was no challenge on individual bed states in the clinical service centres despite evidence of protecting their own bed states, for example, not declaring beds or discharges. Patients had multiple bed moves and were being moved overnight. Vulnerable people (people assessed as not being suitable to move) were being moved. Discharge was being delayed by the poor flow through MAU. Patients suitable for discharge were not routinely identified or plans put in place to move them to other areas to improve flow during the day. The discharge lounge moved on a regular basis, and had varying capacity. There was currently no capacity to take patients in beds, and therefore patients had to wait on wards if they required a bed. This was further congesting an already busy hospital and reducing patient flow options.

Summary of findings

- The staff we spoke with described an executive leadership team who demonstrated a “hands on” rather than strategic mechanism of support. They were involved and physically helped in the department at periods of high pressure. These good intentions were acknowledged by almost all staff. However, these interventions were identified as having little impact. That is, they had been a response to crises rather than the intended leadership to improve the situation. Staff did not feel empowered to make decisions and make changes in their own department.
- Some of the executive team were identified as barriers to the leadership of effective change.
- Senior medical leadership in the emergency department had tried unsuccessfully for a considerable length of time to engage productively with the executive team to produce effective and necessary change. Staff described a culture of “learned helplessness” within the organisation and the level of increased risk had become normalised within the trust. Staff had now accepted a standard of care that was unacceptable.
- Staff we spoke with identified “change fatigue” based on the trust introducing many “solutions” to the ongoing problem. There had been many changes to the emergency pathway which were not followed through. Staff described an environment lacking in grip and pace. When the emergency department became extremely busy or under considerable internal and external pressure, the hospital improvement plan was not always followed. Interim “quick fixes” were put in place but discarded after insufficient time to assess their ongoing efficacy. Staff further described a level of “solution inertia” where the imposition of the short term “quick fixes” had resulted in weary staff who could not see a way forward. It was now accepted, for example, that the 4 hour emergency access target was unachievable.
- The trust improvement plan was not being adhered to. A short stay medical model should have been implemented by the week beginning 29 February. However, staff told us this had not been properly costed and would not now start until April. GP heralded patients were meant to be admitted straight to MAU for assessment and treatment on 15 February. This had changed to 2 March 2016. When we inspected, this service change was not in operation on the evening and night of 4 and 5 March. We had observed on the evening of 3 March that the process had been in place and had worked well. However, when pressure had increased in the department, this practice had been discarded and many staff did not know about the decision. We had not seen any senior leaders supporting the change.
- Data was not being recorded appropriately. Staff told us they were not reporting incidents that had occurred or near misses because of the clinical workload. The number of incidents recorded was low compared to the incidents identified on inspection and identified by staff we spoke with. Figures provided by the trust were being based on averages and did not effectively represent the proportion, or the extremes of patients, having long waiting times for assessment and treatment. Staff were recording information in a way that could not be validated. We observed many patients waiting on a trolley in the ED for over 12 hours and up to 18 hours. We observed that the decision to admit time was recorded in electronic patient record. A 12 hour trolley breach is recorded from the decision to admit for non-clinical reasons. . Assessment and treatment were being delayed and the decision to admit was being delayed based on the medical specialty agreeing to admit the patient. We did not receive assurance that this breach was being measured according to guidance. The trust had only recorded seven 12 hour trolley breaches over 2 December 2015 to 23 February 2016. The time in ED was not being measured in terms of the impact on patients. There were only five vulnerable patients (red patients) recorded as having patient bed moves including overnight from 1 September 2015 to 3 March. However, staff consistently told us they was pressure to move patients and vulnerable patients were being moved.
- We observed an inconsistency of care on the medical assessment unit (MAU). On yellow unit, risks were appropriately recorded on patient care plans and care and treatment was appropriate and timely. However, on the Orange and Lilac units, some patients did not have risks appropriately recorded and observations were not done in a timely way. This was despite some patients having a high risk (for example, at risk of Sepsis) condition.
- Infection control procedures and practices were not consistently adhered to throughout the MAU.

Summary of findings

- The safe storage of medicines was inconsistent in MAU.
- Patients were not always cared for in single sex facilities in the escalation areas.
- There were a high number of patients' moves because of capacity issues.
- Discharge of medical and frail elderly patients from hospital was inconsistent and did not always happen in a timely way.
- There were delays in the development of strategies designed to improve the urgent medical pathway.

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

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

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

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

The trust must also ensure:

- Patients waiting in the corridor, or in ambulance vehicles, must be adequately observed and monitored by appropriately trained staff.
- The hospital must accept full clinical responsibility for patients waiting on the ambulance apron.
- The safe storage of medicines in the MAU.
- Patients are cared for in single sex facilities in the escalation areas.
- Patient notes are stored securely across the hospital to prevent unauthorised access.
- All patients in MAU have care based on plans developed to support identified risks.
- Patients receive timely discharge from hospital.
- Plans to change the urgent medical pathway are implemented in a timely manner.
- Staff in the MAU adhere to infection control policies and procedures.
- There is better and more accurate monitoring information to reflect patient safety and the quality of care.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Rating

Inadequate



Why have we given this rating?

Overall, we rated this service as “inadequate.” This was a deterioration on our overall rating of ‘requires improvement’ at our previous inspections in February and April 2015.

During this inspection, we identified that the trust had made some improvements since the last inspection. However, patient safety was still not assured at all times.

Patients conveyed to the department by ambulance were not consistently clinically assessed within 15 minutes by a member of staff. Observations were not adequately recorded for the patients waiting in ambulances. Patients waiting in the corridor, were not always supervised by staff, and did not have observations consistently recorded to check for deterioration in their condition. Patients waiting in the corridor, when not supervised by staff had no means of calling for help. There was no emergency equipment located in the corridor, such as suction equipment for a patient that had been brought in with seizure activity.

The number of patients waiting in the corridor fluctuated between three and nine. The department’s policy was to have no more than six patients waiting on trolleys in the corridor, supervised by a trained nurse. The ambulance handover nurse was not able to provide adequate supervision for the patients waiting in the corridor, as she was facing away from them, using the computer and dealing with incoming patients and ambulance staff.

The ambulance handover nurse was not always a suitably experienced decision maker at busy times. The process for deciding which ambulance patients should be brought into the corridor queuing area, based on clinical need and risk was arbitrary and inconsistent.

During a patients wait in an ambulance, observations were not carried out, and early warning scores were not used to detect deterioration in the patients’ condition. The location of all patients with a serious condition were not always known, this led to time being wasted and was not safe.

Summary of findings

The trust had not met the national emergency access target of four hours since November 2013 and was one of the 10 lowest performers nationally. There was severe crowding in the ED. The trust had introduced a new system for the referral and admission of medical patients. The decision to admit would now be done by medical teams instead of the ED consultants. This had improved access to a specialist doctor but there were still delays in on-call medical teams seeing patients, once referred, and this had resulted in a new “bottleneck” in the ED. There were delays that were caused by a lack of beds on wards and downstream capacity. These delays in admissions meant that ambulance patients continued to wait in a corridor, some for more than an hour.

The use of the multi occupancy ambulance vehicle for waiting patients had become normal procedure, however this was not a safe or suitable environment for patients.

Patients did not always received the appropriate care and attention and some patients were showing visibly signs of distress and anxiety and distress. The care of frail, elderly patients and vulnerable patients was a concern.

The trust had been slow to improve services following a comprehensive inspection and risks summits in 2015. The trust had also failed to adhere in a timely manner to advice given by the national Emergency Care Improvement Programme (ECIP). Staff displayed exceptional resilience whilst working under pressure but they were not engaged in improvement plans and had experience ‘change fatigue’. Governance process were not working effectively and there was a normalised level of risk. There was not effective leadership across the emergency care pathway.

Staff did not feel empowered to make decisions and make changes in their own department. . Senior medical leadership in the department had tried unsuccessfully for some considerable time to engage productively with the executive team to produce effective and necessary change. Staff described a culture of “learned helplessness” within the organisation and the level of increased risk had become normalised within the trust. Staff had accepted a standard of care that was unacceptable.

Summary of findings

Medical care (including older people's care)

Requires improvement



Overall we rated medicine as “requires improvement”. This is the same as our overall rating at our previous inspection in February 2015. Medical services were rated good for caring. However we rated safe, effective, responsive and well led as requires improvement.

Systems, processes and standard operating procedures were not always reliable, consistent or appropriate to keep people safe. There were some concerns about the consistency of understanding of staff in MAU with regards to infection control procedures. Medicines were not consistently stored securely in the MAU.

Care and treatment was inconsistent within the MAU. Some patients did not receive care based on assessment of risk or plans had not been developed to support identified risks. Patients did not consistently have changes in their condition escalated or responded to.

However, within all the other wards we visited, staff adhered to the trusts infection control procedures. Medications were stored securely and risks to patients were assessed, monitored and managed on a daily basis.

Most patients had assessments for pain throughout their hospital stay and the majority of patients had assessments for their nutritional needs and were supported to eat and drink if required.

Overall, staff had the necessary skills and competencies to provide effective care and treatment. However when some escalation areas were open, staff felt they did not always have the necessary skills to care for some patients.

Staff mainly responded compassionately when patients required help and support. We observed staff spent time talking to patients. We observed some kind, caring and personalised interactions.

However, we witnessed one episode of poor care in MAU which we escalated to senior managers.

Patients were frequently moved which impacted on the timeliness of discharge. Some Patients had multiple bed moves and were moved at night.

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

Patients did not have access to timely discharge from hospital. Operational meetings did not identify

Summary of findings

reasons for the delays in patient discharge, or plans put in place to assess patients waiting for discharge. The discharge lounge was not fit for purpose. The lounge moved on a frequent basis, and was not suitable for patients who required beds. Staff were sometimes unaware of the location of the discharge lounge.

We noted several breaches of same sex accommodation in the escalation areas. However patients who were cared for on the wards had access to same sex facilities.

There were delays in the development of strategies designed to improve the urgent medical pathway. Senior staff described a dis-connect between themselves and directors. Changes in practice were frequently implemented but not always given sufficient time to be fully embedded or be evaluated. The management of patient flow was fragmented and staff did not work together to ensure availability of beds. Some senior managers felt risks to patient care had been “normalised” and not responded to in a timely manner.

We observed clear medical and nurse leadership on the MAU. We observed positive interactions between staff and their immediate leaders in MAU and on the wards throughout our inspection.

Queen Alexandra Hospital

Detailed findings

Services we looked at

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

Detailed findings

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Background to Queen Alexandra Hospital

Queen Alexandra Hospital is the acute district general hospital of the Portsmouth Hospitals NHS Trust. It is the amalgamation of three previous district general hospitals, re-commissioned into a Private Finance Initiative (PFI) in 2009. The hospital has approximately 1,250 inpatient beds, and has over 137,000 emergency attendances each year.

We undertook a comprehensive inspection of Portsmouth Hospital NHS Trust in February and March 2015. At that time we found some patients in the emergency department (ED) were at risk of unsafe care and treatment. We rated the safety of urgent and emergency care services as 'inadequate. We served two warning notices on 4 March 2015, under safety for "care and welfare of patients" and "assessing and monitoring the quality of service provision" in the emergency department. These required the trust to make immediate action to improve the initial assessment of patients, the safe delivery of care and treatment, and the management of emergency care in the ED. A subsequent re-inspection of the emergency department in April 2015 saw improvements, and the service was then rated overall as 'requires improvement'.

Prior to this inspection, we received information of concern about the trust's performance with its emergency pathway from the trust, NHS England, the Trust Development Authority and the Emergency Care

Improvement Programme (ECIP). There had been two risk summits held on 14 December 2015 and 28 January 2016, which had identified significant areas of risk in the trust's emergency care pathway.

Following the first risk summit, the trust was given a number of actions. These were reiterated at the second risk summit due to a lack of initial progress, to: introduce Safer Start, a system to accelerate discharge, develop a short stay patient model of care, ensure that expected GP patients went directly to the medical assessment unit, change the medical model for emergency admissions, introduce a frailty interface team, focus on reducing the variation with simple discharge and complex discharges and introduce 'discharge to assess'. The trust was also required to work with the Emergency Care improvement Programme (ECIP) and ensure their recommendations were implemented

On February 22 and 23 and March 3 and 4, 2016, we undertook unannounced and focused inspections of the emergency care pathway at Queen Alexandra Hospital. The focus of our unannounced inspection was on the actions taken by the trust in response to the identified risks to patients through their emergency care pathway. We inspected two core services Urgent and emergency care and medical services. This included the emergency department (ED), medical assessment units, medical wards and other areas where patients may follow an emergency care pathway after admission via the ED. We did not inspect any of the other core services at this time.

Detailed findings

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Joyce Frederick, Care Quality Commission

The team included two CQC managers, four inspectors and specialists advisors, including two medical consultants, one with extensive experience of working within an emergency department, a Head of emergency department nursing, and a senior board level manager.

How we carried out this inspection

Prior to the inspection, we collated and discussed current relevant and pertinent information and metrics from the trust, NHS England, the Trust Development Authority and the Emergency Care Improvement Programme (ECIP).

On February 22 and 23 and March 3 and 4, 2016, we undertook unannounced and highly-focussed inspections of Portsmouth Hospital NHS Trust to follow

up on these wide-ranging and serious concerns. We inspected the ED and also assessment units, medical wards and other areas where patients may follow a pathway after admission via ED.

We spoke with patients, carers, relatives, staff, senior leads and the Executive team. We observed care, carried out interviews and attended bed meetings.

Facts and data about Queen Alexandra Hospital

A data pack was not used for this inspection due to the availability of current external data from the sources listed above. We reviewed the trusts performance information before, during and after our inspection.

Our ratings for this hospital







Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Not rated	Requires improvement	Inadequate	Inadequate	Inadequate
Medical care	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Inadequate	N/A	N/A	N/A	N/A	Inadequate

Notes

We have not rated 'Effective' as we did not have sufficient evidence to provide a rating.

Urgent and emergency services

Safe	Inadequate	
Effective	Not sufficient evidence to rate	
Caring	Requires improvement	
Responsive	Inadequate	
Well-led	Inadequate	
Overall	Inadequate	

Information about the service

Queen Alexandra Hospital is the acute district general hospital of the Portsmouth Hospitals NHS Trust. The hospital has approximately 1,250 inpatient beds, and has over 137,000 emergency attendances each year. The emergency department (ED) at Queen Alexandra Hospital is open 24 hours a day, seven days a week. It treats people with serious and life-threatening emergencies and those with minor injuries that need prompt treatment such as lacerations and suspected broken bones. The ED is a recognised trauma unit, although major trauma cases go directly to Southampton.

The department was large with a separate area for the triage and treatment of children. The waiting room had a reception desk and three triage assessment rooms for walk in patients. The minor's area had two treatment cubicles, including one used by a GP and advanced nurse practitioner to see minor illness patients. There were also three cubicles for patients to be treated.

The majors area consisted of a four bedded resuscitation room, one of these bays was equipped for the children and infants. Opposite the resuscitation room there was also a room, with two trolleys, used for ambulance transfers and investigations on patients that were not able to be accommodated within the department permanently, such as those waiting in ambulances. Outside this room was a corridor used for accommodating patients waiting on trolleys. There were

13 bays in the majors waiting area and a further 18 in the major's area with three cubicles. There was an observation ward of nine beds (this was maintained a single sex area).

There is a small urgent care centre where patients can be treated by a GP if their condition is not an accident or emergency. We did not inspect the urgent care centre.

We undertook a planned comprehensive inspection of Portsmouth Hospital NHS Trust in February and March 2015. At that time, we found some patients in the Emergency Department (ED) with serious conditions waiting over an hour to be clinically assessed. The trust had introduced an initial clinical assessment by a healthcare assistant to mitigate risks, but this was not in line with national clinical guidelines. Many patients waited in corridors and in temporary bay areas and patients were not adequately observed or monitored. Patients in some areas used for waiting did not have timely access to essential equipment or call bells.

Patients were not being seen by a speciality doctor in a timely way to assess their clinical needs. Medical and nurse staffing levels had not been adequately increased to take account of the number of patients in the department.

Patients who arrived by ambulance at the emergency department (ED) were at risk of unsafe care and treatment. We served two warning notices on 4 March 2015 under safety for "care and welfare of patients" and "assessing and monitoring the quality of service provision" in the emergency department. These required the trust to make immediate action to improve the initial

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assessment of patients, the safe delivery of care and treatment, and the management of emergency care in the ED. We rated the safety of urgent and emergency care services as 'inadequate.' Subsequent re-inspection in April 2015 saw improvements and the service being rated as 'requires improvement'.

This inspection:

We undertook this unannounced focused inspection of the emergency care pathway at Queen Alexandra Hospital following concerns raised by risks summits held in December 2015 and January 2016. The focus of our unannounced inspection was on the actions taken by the trust in response to the identified risks to patients through their emergency care pathway

The inspections took place on 22 and 23 February and the 4 March 2015. The inspection team of four included two CQC inspectors, and specialist advisors who were a consultant in medicine, and a Head of ED Nursing.

During this inspection we spoke to approximately 40 members of staff, 19 patients and four relatives. We looked at 13 sets of care records as well as policies and other documents.

Summary of findings

Overall, we rated this service as "inadequate." This was a deterioration on our overall rating of 'requires improvement' at our previous inspections in February and April 2015.

During this inspection, we identified that the trust had made some improvements since the last inspection. However, patient safety was still not assured at all times.

Patients conveyed to the department by ambulance were not consistently clinically assessed within 15 minutes by a member of staff. Observations were not adequately recorded for the patients waiting in ambulances. Patients waiting in the corridor, were not always supervised by staff, and did not have observations consistently recorded to check for deterioration in their condition. Patients waiting in the corridor, when not supervised by staff had no means of calling for help. There was no emergency equipment located in the corridor, such as suction equipment for a patient that had been brought in with seizure activity.

The number of patients waiting in the corridor fluctuated between three and nine. The department's policy was to have no more than six patients waiting on trolleys in the corridor, supervised by a trained nurse. The ambulance handover nurse was not able to provide adequate supervision for the patients waiting in the corridor, as she was facing away from them, using the computer and dealing with incoming patients and ambulance staff.

The ambulance handover nurses did not always make consistent decisions at busy times. The process for deciding which ambulance patients should be brought into the corridor queuing area, based on clinical need and risk was arbitrary and inconsistent.

During a patients wait in an ambulance, observations were not carried out, and early warning scores were not used to detect deterioration in the patients' condition. The location of all patients with a serious condition were not always known, this led to time being wasted and was not safe.

The trust had not met the national emergency access target of four hours since November 2013 and was one

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of the 10 lowest performers nationally. There was severe crowding in the ED. The trust had introduced a new system for the referral and admission of medical patients. The decision to admit would now be done by medical teams instead of the ED consultants. This had improved access to a specialist doctor but there were still delays in on-call medical teams seeing patients, once referred, and this had resulted in a new “bottleneck” in the ED.

There were delays that were caused by a lack of beds on wards and downstream capacity. These delays in admissions meant that ambulance patients continued to wait in a corridor, some for more than an hour.

The use of the multi occupancy ambulance vehicle for waiting patients had become normal procedure, however this was not a safe or suitable environment for patients.

Patients did not always received the appropriate care and attention and some patients were showing visibly signs of distress and anxiety and distress. The care of frail, elderly patients and vulnerable patients was a concern.

The trust had been slow to improve services following a comprehensive inspection and risks summits in 2015. The trust had also failed to adhere in a timely manner to advice given by the national Emergency Care Improvement Programme (ECIP). Staff displayed exceptional resilience whilst working under pressure but they were not engaged in improvement plans and had experienced ‘change fatigue’. Governance process were not working effectively and there was a normalised level of risk. Staff did not feel empowered to make decisions and make changes in their own department. . Senior medical leadership in the department had tried unsuccessfully for some considerable time to engage productively with the executive team to produce effective and necessary change. Staff described a culture of “learned helplessness” within the organisation and the level of increased risk had become normalised within the trust. Staff had accepted a standard of care that was unacceptable.

Are urgent and emergency services safe?

Inadequate



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

- We found there were excessive delays to patients brought to the department being assessed and treated.
- Patients that were waiting in ambulances and in corridors were not appropriately observed at all times. Observations used in the initial triage assessment were recorded by the ambulance service and not hospital staff. As a result these observations were not contemporaneous with the initial assessment.
- There was an inconsistent use of the early warning score system designed to help clinician assess if a patient is deteriorating.
- There was a lack of senior clinical decision making to ensure that the patients waiting in ambulances were more appropriate to be seen by a different treatment pathway, for example, minor injuries, ambulatory care or minor illness GP service.
- The overcrowding within the department meant that patients were being moved around and location of some patients with serious condition was not always known.
- Patients that were elderly or frail were put onto hospital beds if they were to be waiting in the major’s area. Although a risks assessment of pressure ulcers was not always completed, patient’s skin was inspected by nursing staff.
- Infection control procedures were not appropriately followed.
- The major’s area was accommodating patients for prolonged periods without access to hot food. Department staff told us they were not permitted to order hot for patients in the majors waiting areas. We observed patients receiving sandwiches whilst in these areas.
- Safeguarding procedures were not always being appropriately followed for vulnerable adults.
- Medical consultant staff were working unsustainably long hours to cope with the demands in the emergency department.

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- Nursing staffing levels were not always as planned by the trust and this meant that patients were not always appropriately assessed and monitored. Essential information of patients was sometimes missing in the handover of patients.

Incidents

- Staff reported some incidents, but due to the consistent pressure on the department, staff admitted that they do not report all issues that should be reported as incidents. Staff told us that they had lost confidence in the governance system and did not see changes occurring as a result of reporting incidents.
- We tracked one serious incident to identify how the process was being used. On the 15 February there had been a serious incident reported, where a patient accommodated in the Jumbulance had deteriorated into cardiac arrest, this was undergoing a formal investigation process. There was no feedback from this incident available to us on inspection on 22 February. There was an initial management report completed however. Immediate action subsequent to this incident was to remove the Jumbulance from the hospital and only reinstate the use of this resource with executive approval. There were suitable extra cubicles to be put into use for those patients that would have been held in the Jumbulance.

Cleanliness, infection control and hygiene

- We found that some equipment used in the department was not properly cleaned; this was escalated to staff during the inspection. For example, there were blood splatters on the blood gas analysis machine and on the wall and floor in the resuscitation room.
- Patients with potential infections were isolated from other patients in majors, and appropriate steps were taken to stop the spread of infection. Cubicles were deep cleaned when patients moved out of them.
- There were sufficient supplies of hand gels and personal protective (PPE) equipment for staff to use. However, we saw staff leaving rooms during patient care with PPE still in place. For example, we saw a doctor looking for equipment while still wearing a glove used for patient care.

Environment and equipment

- The department was large with a separate area for the triage and treatment of children, this included a waiting

room that was suitably equipped and decorated. The waiting room had a reception desk and three triage rooms. The minor's area had two treatment cubicles, including one used by a GP and advanced nurse practitioner to see minor illness patients. There were also three cubicles for patients to be treated.

- The majors area consisted of a well-equipped four bedded resuscitation room, one of these bays was equipped for children and infants. There was a separate room with two trolley bays for ambulance handover. There were 12 bays in the 'majors waiting' area and a further 18 in the major's area with three cubicles. There was an observation ward of 9 beds (this was maintained as a single sex area). There was also a room used for ambulance transfers and investigations on patients that were not able to be accommodated within the department permanently, such as those waiting in ambulances.
- The corridor area outside the ambulance handover room was referred to as the 'HALO area' although there were no hospital ambulance liaison officers (HALOs) observed in the department. This was used for six patients as a trolley waiting area. However, on the inspection 4 March 2016 it was used to accommodate eight waiting patients, later that night we observed nine patients waiting. During our inspection it was regularly used for more than six waiting patients.
- Extra trolleys were sometimes used in the majors waiting area to increase capacity. These spaces were not always equipped with curtains or call bells.
- Staff checked the resuscitation equipment against a standard checklist. However, the checklists recorded that there had been 16/31 daily checks missed in January 2016 and 14 in February 2016. There was inconsistency in the format of the different checklists used for emergency equipment in the resuscitation room, with some being calendar and others requiring the checker to complete the date. This meant it was more difficult for managers to see gaps were checking was not completed.
- Monitoring equipment in the resuscitation room was also subject to a daily check against a checklist. This recorded that in January 2016 this was omitted for 25/31 days and for 18/29 days in February 2016.

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- The 'difficult airway' trolley had no calendar checklist and was therefore a different format to other emergency equipment checklists. During January 2016 the daily check on this equipment was omitted on 14/31 occasions, and for 16/29 occasions in February 2016.
- Standby emergency equipment in the assessment room opposite the resuscitation room was on a grab board. The emergency equipment supplies on the board were not sterile, as the packaging had been pierced with the hooks holding supplies onto the board. This was escalated to the nurse in charge as this equipment was not suitable for patient use.
- The department had access to hospital beds to allow elderly patients to be nursed on appropriate pressure relieving devices such as alternating air mattresses in majors.
- The children's waiting room was suitably decorated and toys were available for small children. The environment was pleasant and secure from the main waiting room. Treatment rooms for triage and treatment of children were also separate from adult facilities.

Medicines

- Temperature recording of medicine refrigerators in the resuscitation room was inconsistent. In January 2016 the daily temperature check was carried out on nine occasions, in February on six occasions. Although the minimum and maximum temperatures were recorded in the refrigerator that contained anaesthetic medicines, daily checks on temperature were omitted on 22 days in January and February 2016.
- Medicines stored in the department were spot checked and found to be in-date and stored securely. Controlled drugs were stored securely and appropriately.
- Patient allergies were recorded on the prescription charts we reviewed. There was a departmental protocol for the prescribing of antibiotics that staff adhered to.

Records

- Records were completed on the electronic system during patients stays in the department. These were printed on paper when the patient was transferred to the Acute Medical Unit (AMU) or to a ward.
- Nursing staff assessed the skin integrity of patients that waited in the major's area to be admitted to wards or the AMU.

- Risk assessments for pressure ulcers, the use of bed rails and venous thromboembolism were not completed until admitted to the ward area. Some elderly patients however, remained in the majors area for prolonged periods of time.
- Due to the chaotic nature of the department, we witnessed that some patient records were lost, including the results of tests and blood samples. The chaotic environment led to the misplacing of investigation requests, results and clinical samples, compounding delays to diagnosis and appropriate treatment. On 23 February, a patient's ECG had to be redone on transfer to AMU as the one completed in ED had been lost. The same patient had also had to provide a second blood sample as the first had not been received by the laboratory

Safeguarding

- Procedures for safeguarding vulnerable adults were not always followed. For example, during our inspection we observed that a patient admitted with a mental health problem did not have a safeguarding concern raised about her partner due to poor handover procedures. A violent incident had occurred at the patient's home and a member of ambulance staff was assaulted, however this information was not passed to staff in AMU. The whereabouts of the patient's partner was not known. This was a potentially serious oversight as the partner could have attended to hospital, and the patient was in fear of her life.
- Children's safeguarding and child protection arrangements were appropriate. Staff identified parental responsibility. The electronic system used across the department provided a template for staff to follow and record responses.

Mandatory training

- Records of mandatory training were not looked at during this unannounced inspection.

Assessing and responding to patient risk

- Ambulance staff recorded observations before arrival, these were copied over onto the Adult Immediate care needs and unified prescription sheet, but into the space on the sheet reserved for the initial ED observations. This meant that the observations used to inform the immediate healthcare professional assessment was out of date. The ED nurses that checked patients in the

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ambulances did not record any additional observations. The reason they gave for this was that they were not familiar with the equipment on the ambulance. Patients were therefore left without having observations recorded during the wait in the ambulance.

- Patients that were waiting in ambulances did not have access to nurse assessment in all cases. This meant there was a risk that essential care for vulnerable people would not occur.
- The use of an early warning system score was inconsistent across the whole department. When they were used, such as in AMU using an electronic system, staff were unclear what action to take when the early warning score was elevated. The observations recorded were not consistently used to calculate an early warning score that could be used to assist with triage. We saw that some early warning scores that were calculated without recording the patient's temperature, this is an important flag in assessing the risk of sepsis.
- The corridor area outside the ambulance handover room, known as the 'HALO area' was used for 6 patients as a trolley waiting area. However, during the night of 4 March this area always had more than 6, and up to 9 patients waiting. This was normal practice within the department. There was no emergency equipment located in the corridor, such as suction equipment for a patient that had been brought in with seizure activity.
- There were escalation procedures in place that were used for patients waiting in ambulances. However, these were not always followed by staff. We observed empty beds in the observation ward during a period of peak demand.
- There were patients that if assessed promptly could have used the urgent care centre in order free up capacity within the ED. There was evidence that rapid assessment and treat (RAT) processes were not sufficiently used across the department.
- During busy periods the triage system appeared to break down, with staff unsure about the acuity of patients waiting in ambulances. Without the use of early warning scores or an initial assessment process for waiting ambulance patients, this risk was not mitigated.
- Time to initial assessment in the major's area varied significantly, with some patients waiting in excess of an hour before any initial assessment was carried out. We identified patients with serious conditions, such as chest pain, suspected sepsis, fractured neck of femur

and stroke that had not been triaged, assessed or treated within the 15 minute standard. Although the trust data was in averages, it reported that less than half of ambulance patients were assessed within this time.

- In February we tracked five patients with potential life threatening conditions (neutropenic sepsis, on chemotherapy. Suspected sepsis, acute coronary syndrome, overdose of Lithium, and congestive cardiac failure with delirium). None had been assessed within 15 minutes. These patients waited for 2 hours 52 minutes, 27 minutes, 34 minutes, 3 hours 52 minutes and one had initial triage at 1 hour 14 minutes with a first assessment time recorded at 5 hours and 23 minutes.
- Multiple poor quality handovers between staff around the unit meant that important information was not always communicated.. For example, a patient transferred between majors and AMU with a deliberate overdose with a known mental health problem, should not have been allowed to leave the department. However, this was not communicated to staff and she was allowed to leave in order to smoke. A junior doctor followed the patient out of the ward and requested that she return, having briefly looked at her notes.
- In the minors area there were three triage cubicles in use. Triage for patients in the minor's area was effective and safe. Patients attending the department via the waiting room were observed being initially assessed consistently within 15 minutes.
- The flow issues through the hospital led to patients being moved around the department multiple times. This led to a high numbers of handovers between staff that were not always effective and safe. The location of all patients with a serious condition were not always known, this led to time being wasted and was not safe. For example, on the 22 February a patient with a potentially serious brain injury that had been assessed in an ambulance was unaccounted for by the ambulance handover nurse. The patient had been urgently moved to the CT scanner, but this took time to find out.

Nursing staffing

- There numbers of qualified nurses in the department were not as planned to meet the demands of patient numbers and acuity. This frequently left patients waiting in the corridor waiting area inadequately observed. For example, we saw a nurse squeezing an intravenous infusion bag as it was not running fast enough. The

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corridor nurse had not been monitoring this infusion. Patients waiting in the corridor did not have any means of calling for help, except for hailing a member of staff if they were able. During our inspection 4 March, at 9pm there were 8 patients waiting in the corridor. Staffing then was 2 healthcare support workers and one trained nurse: this was an insufficient number to provide assessment and on-going monitoring for patients that had just arrived by ambulance. The ratio of staff to patients should be 1:4 according to trust guidance. Although there were patients being held in ambulances, there was no nurse allocated to provide initial assessment.

- Nursing staff worked flexibly to cover different areas of the department during busy periods. For example, on the night of the 4 March 2016 as four ambulances arrived, the nurse from majors waiting area was asked to accompany the duty consultant out onto the ambulance apron. This meant that there were now two staff observing and caring for patients in the major's waiting area. Although this left a staff ratio of 1:6 and 1:7 in this area that was below the departments' own safe staffing planned levels, there was a nurse co-ordinator dedicated to the area to provide support for the nursing staff. It was acknowledged that this was done in response to the elevated level of risk presented by the arrival of 4 ambulances at the same time.
- Handovers of individual patients were frequent between several nurses, as patients were relocated around the department and subsequently to the medical assessment unit. Some staff from other departments (nurse specialists) were used as transfer escorts from the major's area. However, we found that some key aspects of a patient's care were not handed over accurately. For example, a patient with mental health problems arrived on the MAU and immediately went to leave to department to smoke. The recommendation that the patient did not leave the department unescorted was not handed over to MAU staff, including the threat of violence from the patient's partner, whose whereabouts was unknown.
- We observed that the handover of a diabetic patient with acute kidney injury was ineffective, as a GP letter had not been given to the ambulance handover nurse by reception until three hours after the patient had been assessed. This letter contained important diagnostic information for the patient.

- During our inspection of the 4 March 2016 there was an administrative officer on duty between 10am and 6pm. However, when the administrative officer was not on duty it meant that when patients were able to be transferred to AMU or a ward, nurses had to print out the patient ED care record. Staff told us that this extra task put pressure on them and took them away from carrying out patient care.
- In the minors area the urgent care centre was supported by advanced nurse practitioners to treat patients presenting with minor illnesses.

Medical staffing

- During the day there were usually four consultants on duty. However, from midnight there was a single middle grade doctor rostered.
- There was consultant cover in the department for more than 16 hours per day. However, consultants told us that they were often not able to leave the department at the end of their shift and had to work extra hours to support more junior doctors. Due to the increasing workload of the department, consultants often worked until 2am (shift finish times were midnight). On the second night of our inspection, the consultant worked until 5am. The staff doubted that these working practices could be sustained, despite the best of intentions by the staff.
- Each morning, a consultant reviewed every patient who had remained in the department overnight. During our inspection this included up to 14 patients who had been referred to specialist medical teams and were waiting to be admitted to a ward. Specialist doctors had not seen the patients during the night and so the ED consultant reviewed them in order to ensure that they were being appropriately treated. This added considerably to the consultant workload and meant that there was less time to treat ED patients.
- There were five middle-grade doctors working in the department, which was lower than the national average. This meant that only one middle-grade doctor would work at night. Because of the layout of the department, this meant that these experienced doctors could not always ensure the safety and timely treatment for the sickest patients, as they were not always easily viewable.
- In response to this, the consultants worked additional hours in order to ensure patient safety. With their existing work commitments, this solution was not sustainable.

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- There was a GP that worked in the department to provide the urgent care service in majors. This service was in operation between 10am-10pm, 7 days a week.
- There were effective handovers meetings for medical staff. This included a post-take ward round, that was well organised.

Major incident awareness and training

- There were security staff in the department from 9pm-5am daily. These staff had received training in conflict resolution and physical restraint.

Are urgent and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

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

We did not collect sufficient data to make a rating in effective.

- Patient's pain was not always assessed in a timely way during busy periods.
- We observed that patients that could eat and drink were not always offered food and drinks.
- Patients awaiting review for mental health problems had to wait for long periods in the majors and 'majors waiting' areas.
- Admission avoidance pathways, such as ambulatory care and urgent care, were underutilised.
- The treatment when given took account of evidence and national guidance although recommendations on the timeliness of care were not being met.

Evidence-based care and treatment

- The ED department used a combination of NICE and Royal College of Emergency Medicine (RCEM) guidelines to determine the treatment that was provided. Guidance was discussed at risk and governance meetings, disseminated and acted upon as appropriate.

- The department satisfied the requirements of the national "Standards for children and young people in Emergency Care settings".
- The ED participated in a number of national audits, including those carried out on behalf of the Royal College of Emergency Medicine (RCEM). During this unannounced inspection we did not look at the outcomes of CEM audits.
- We observed staff providing care and treatment in line with national guidance. However, recommendations inherent within guidelines on the timeliness of assessment and emergency treatment were not being met.

Pain relief

- Delays to assessment and treatment meant that patients may not always receive pain relief in a timely manner. However, we did not observe that any patients were complaining of pain during the inspection.

Nutrition and hydration

- Patients in the majors waiting and majors areas of the department only had access to cold food. There was no provision for hot food even if the patient had been in the department for more than 12 hours.
- Water was not always available for patients in the majors areas.
- Patients in the observation ward had access to hot food at mealtimes.
- There was a refrigerator specifically for bottles of water that were given to patients in the resuscitation room.

Patient outcomes

- Although the ED participated in a number of national audits, including those carried out on behalf of the Royal College of Emergency Medicine (RCEM) we did not review these as part of our unannounced inspection.

Competent staff

- Not inspected as part of the focused inspection.

Multidisciplinary working

- Psychiatric input for patients with a mental health problem was not timely due to the Mental Health Providers own capacity issues. We found two patients waiting in the majors department in excess of 20 hours awaiting a mental health assessment.

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- There were admission avoidance pathways in place but these were not always utilised to full effect, such as ambulatory care. It was unclear why this was not used, but staff told us there were sometimes difficulties in staffing the unit.
- There were therapy staff that were available to help assess patients in the ED.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed that staff asked patient's consent before carrying out observations, examinations or care.

Are urgent and emergency services caring?

Requires improvement 

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

We rated caring as requires improvement

- Staff were trying to treat patients with compassion and kindness but this was being hindered by the pressures within the department.
- Many patients did not receive any appropriate care on arrival in the department. Many patients, including frail, elderly and vulnerable patients, were left unsupported and did not receive adequate care. There were patients showing visible signs of anxiety and distress.
- The privacy and dignity of patients was compromised when patients were waiting in ambulances and on trolleys in the corridor spaces.
- Some patients told us they had received communication about their care and treatment that was inconsistent.

However,

- Patients in the majors and waiting areas received appropriate care and attention from staff. We observed some good care being given in the major's area.

Patients recognised that staff were busy and were supportive of staff. They told us they had received explanations about their care.

Compassionate care

- The staff in the department were working under considerable pressure due to severe overcrowding.
- We observed staff treating patients with dignity and respect in the majors and majors waiting areas.
- We observed some patients did not receive any care on arrival in the department. They were left unsupported and with their needs unmet.
- We observed many patients waiting in ambulances and in the corridor who were not supervised and did not receive adequate care and attention of staff. Many patients were frail and elderly and vulnerable. There were patients who were trying to ask staff for help but were unable to and there was a lack of privacy and dignity for these patients who were waiting in exposed areas.
- There were sometimes additional trolley spaces used and these did not have curtains to allow for the privacy and dignity of patients.

Understanding and involvement of patients and those close to them

- Patients told us that the care in the department was good, and that the staff worked extremely hard and were not to blame for the long waiting times.
- Patients told us they had had explanations about their care and treatment although this was sometimes inconsistent when there was communication from different staff.

Emotional support

- Although all staff were under considerable and on-going pressure to provide care across the department, they were approachable and treated patients with kindness and respect.
- Some families of acutely ill patients were supported in the department. Staff offered appropriate emotional support to the relatives of end of life care patients. However, there were some patients and relatives waiting in ambulances and the corridor who did not receive care or appropriate attention and involvement. There were many patients showing visible signs of anxiety and distress but nursing was too busy to attend to or even observe their physical and emotional needs.
- We observed and intervened when a vulnerable patient with mental health needs exited the building, putting herself in physical danger, as staff had been unable to respond to her needs.

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

Inadequate



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

We rated responsive as inadequate.

- The emergency department at the hospital was severely overcrowded and escalation plans were not appropriately followed.
- The Urgent Care Centre was under-used.
- Patients brought to the hospital by ambulance were subject to long delays for assessment and treatment.
- Patients were waiting in corridors and in ambulances. Some patients had to wait in a facility in an inappropriate external facility (called a Jumbulance) that did not have heating.
- As a result of ambulances stacking outside the hospital, capacity of the ambulance service to respond to urgent 999 calls was seriously affected. At times, one-third of the emergency ambulance fleet for Hampshire were waiting outside the hospital's ED.
- The flow issues through the hospital led to patients being moved around the department multiple times. This led to a high numbers of handovers between staff that were not always effective and safe. The location of all patients with a serious condition were not always known, this led to time being wasted and was not safe.
- There was an inconsistency in the responsiveness of different medical teams across the hospital, with some seeing expected patients in ED, others leaving referred patients to be seen and assessed by ED doctors. This was causing further delays in admitting, transferring and discharging patients.
- The trust had not met the national emergency access target of 4 hours since November 2013 and was one of the 10 lowest performers nationally.
- Patients with mental health problems were not being seen by the mental health team in a timely way. This meant that patients could be waiting in the department for long periods.
- There was not enough consideration given of the needs of patients with a learning disability.

Service planning and delivery to meet the needs of local people

- The trust had experienced an increase of 4.6% attendances at the department; this was higher than the 1% national increase across England. This calculation increased to 7.3%, if GP expected patients, and those that were attending the urgent care centre were included.
- The pressure within the department was causing severe crowding, this led to patients being relocated many times throughout the department. Patients waiting in corridors and in ambulance.
- The Urgent Care Centre had been opened for six months. This included four bays and one cubicle and was awaiting redesign. There was one acute physician supported by emergency nurse practitioners to provide treatment on the unit. However, staff told us that its capacity was often restricted by a lack a nursing staff.
- The trust had yet to demonstrate appropriate use of the Urgent Care Centre. Where there were delays in moving patients out of the AMU, this meant that GP expected patients still had to be admitted via the ED, this was adding to the overcrowding.
- There was a community based team of five senior nurses (2x band 7 and 3x band 6), and one Health Care Support Worker, that worked in admission avoidance and facilitated discharge. This team is an integral part of the Frailty and Interface Team (FIT). The team worked from 8am-6pm, 7 days a week. This team facilitated an average of five discharges a day. The Trust funded component of FIT has four registered nurses and two healthcare support workers and operated from 8am-8pm.

Meeting people's individual needs

- The ED waiting room had sufficient seating for waiting patients. Children that attended the department were immediately asked to go through to the children's waiting room by reception staff. Children were seen and treated in a designated area of the ED. There was a separate waiting room and triage cubicle for children, these facilities were accessed by a secure door operated by the reception staff.
- Patients with a learning disability and those living with dementia did not always have reasonable adjustments to take account of their vulnerability. Their pathway

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through the department was the same as patients that were not vulnerable. For example, we observed a patient conveyed to the department by ambulance that had a learning disability. The patient was waiting in an ambulance and showing signs of distress. The patient was not adequately supported and waited in the vehicle for 2.5 hours. There was no capacity in the queue to allow this patient to take priority.

- Patients that were confused or that were living with dementia could not be guaranteed privacy and dignity when waiting in the ambulance queue.
- Patients in majors that had been referred to the mental health team had to wait for prolonged periods in the department. For example, one patient we observed waited in majors for 23 hours. The ED is not a suitable environment for patients that have been admitted with mental health problems.
- Some elderly patients had to wait for periods in excess of over 1 - 2 hours in the corridor.
- Side rooms were used for patients that attended the department that required end of life care.

Access and flow

- The trust performance against the 4 hour national emergency access target was one of the lowest in Hampshire. In January 2016 the trust recorded 68.8% against a national average of 83%. The trust had not met the target since November 2013 and was one of the 10 lowest performers (fifth) in the country.
- Due to poor flow through the department there were often ambulances held at the hospital with patients unable to access the department. On 22 February 2016 at 7pm there had been 16 ambulances queuing outside the department. This represented a third of the South Central Ambulance Service (SCAS) South East ambulance fleet being held at Queen Alexandra Hospital. This meant there had been capacity issues for the ambulance service, that had to hold eleven 999 emergency calls due to a lack of local vehicles available for dispatch. This situation was repeated on the 23 February 2016 at 4pm and overnight. Due to the impact on SCAS the 'Jumbulance' (an ambulance vehicle that could accommodate up to 4 waiting patients) had been re-opened to allow emergency vehicles to go back into service. The 'Jumbulance' was cold and unsuitable for the purpose for which it was frequently being used.

- On the 22 February SCAS recorded there was a total of 93 hours of excess handover time, and a further 84 hours the following day. The average handover time during 22 and 23 February was 61.5 minutes.
- Patients were being moved around the department. For example, we observed that the location of one patient, with a suspected serious condition, was not known by the ambulance handover nurse. It took time to locate this patient urgently, which added to an already pressured situation.
- There were escalation procedures in place that were used for patients waiting in ambulances. However, these were not always followed by staff. We observed empty beds in the observation ward during a period of peak demand.
- Medical teams did not have general medical beds available for admitting patients. It was not always clear which was the admitting consultant responsible for the patient's care. We followed one patient through to the ward and noted that although an on-going cancer patient, they were admitted under gastroenterology and oncology.
- During our inspection we observed that in majors there were 26 patients that had the decision to admit made, of these 23 were medical patients. This led to the major's area being used as a holding area, where patients would often be subject to long waits. There was an acceptance that the major's area was invariably filled with medical patients.
- The ED departments 'conversion rate' that is the number of patients attending the department that were subsequently admitted was 35.5% this is higher than the England average of 24%.
- During our inspection, the hospital reported that there were 90-150 patients that were medically fit and awaiting discharge. When discharges delays over 24 hours were removed from this number, there were 50 simple discharge delays and transfers of care.
- The trust escalation procedures had not been followed the number of ambulances waiting outside of the trust, number of patients waiting in the corridor, assessment and treatment, the input of specialty teams, and discharge procedures.
- The escalation processes that were in place had become normal for the department. The department was running in excess of the scenario described in the standard operating procedure for full capacity in the

Urgent and emergency services

emergency department. This document referred to the use of the 'Jumbulance' for accommodating waiting ambulance patients as a normal process that contributed to the department's capacity

Learning from complaints and concerns

- Not inspected as part of the focused inspection.

Are urgent and emergency services well-led?

Inadequate



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

We rated well-led as inadequate

- The trust had been slow to improve services following a comprehensive inspection and risks summits. The trust had also failed to adhere in a timely manner to advice given by the national Emergency Care Improvement Programme (ECIP).
- Staff did not feel empowered to make decisions and make changes in their own department. Senior medical leadership in the department had tried unsuccessfully for some considerable time to engage productively with the executive team to produce effective and necessary change. Staff described a culture of "learned helplessness" within the organisation and the level of increased risk had become normalised within the trust. Staff had accepted a standard of care that was unacceptable.
- We saw that the staff within the ED were working to and beyond capacity. There was significant and constant pressure on staff from a high number of patients waiting to be assessed and treated. However, this situation had been normalised. Staff told us that there was little impact of the hospital being on Black alert, as this occurred frequently. Escalation plans no longer had an impact on the staff in the ED.
- Governance processes were not working appropriately. Staff told us that they were not reporting all incidents or monitoring risks due to clinical workload, and there was

a normalisation of elevated risk. As a result, standards of care were far less than others would find normally acceptable, but this was viewed as the "difficult norm" in the department.

- There was insufficient clinical engagement in improvement and escalation plans.
- Staff told us that there were plans to make improvements to access and flow through the department, but that they were not consulted about them.
- Staff were unconvinced that planned changes would lead to improvements in the flow of patients through the department. There was frustration and change fatigue about the lack of effective change.
- There was a lack of clear ownership and leadership for the emergency care pathway across the emergency and medical services.

However,

- Staff we spoke to were tired and frustrated, although they were supportive of each other.
- Staff in the ED demonstrated a firm resilience whilst working under extreme pressures.
- They were supportive of each other and identified good local leadership.

Vision and strategy for this service

- The risk summits held after the comprehensive and follow-up inspections in 2015 had reported a slow level of progress with the requirements despite the trust being well resourced and supported. The trust had failed to adhere to advice given.
- ECIP reported the trust had normalised the level of risk, externalized blame (someone else's problem and the problem was too complex and too difficult) and there was mistrust across the system. The trust were tasked to ensure clinical leadership was engaged and to focus on the emergency pathway (this was the third model for emergency flow in the last 12 months), and for the pathway to be prioritised within the Trust.
- The trust developed a revised improvement plan 2016/17 that indicated the new phases of development.
- Ensuring the ED was used appropriately
- Preventing unnecessary attendance and admission
- Introducing a frailty intervention team

Urgent and emergency services

- A new medical model for speciality teams seeing medical patients on the day of admission simplifying the approach to medical take
- Geographically based care – where all patients on a ward are the responsibility of that speciality team unless it is in the best interests of the patient to transfer their care to another speciality team
- Estimated date of discharge set on admission by frailty or medical consultants teams.
- Increasing the identification and management of short stay medical take patients to the national average of 65% through a short stay model of care.
- Due to the failure of recent changes to medical staffing, staff expressed scepticism that some of the proposed changes would work and improve the running of the department. There was no long term strategy for the department itself, with the focus remaining on dealing with severe overcrowding and ambulance stacking.
- Staff told us they had not been suitably engaged with improvement plans.

Governance, risk management and quality measurement

- Quality measurements had been developed for the planned improvements in the emergency department. However, many staff in the service had not been involved in their development and were not aware of these.
- Current data was not being recorded appropriately. Staff told us they were not reporting incidents that had occurred or near misses because of the clinical workload. The number of incidents recorded was low compared to the incidents identified on inspection and identified by staff we spoke with.
- Figures provided by the trust were being based on averages and did not effectively represent the proportion, or the extremes of patients, having long waiting times for assessment and treatment. Staff were recording information in a way that could not be validated. We observed many patients waiting on a trolley in the ED for over 12 hours and up to 24 hours. A 12 hour trolley breach is recorded from the decision to admit for non-clinical reasons. We observed that the decision to admit time was not being recorded in patient records. The decision to admit was recorded on the computer. Assessment and treatment were being

delayed and the decision to admit was being delayed based on the medical specialty agreeing to admit the patient. We did not receive assurance that this breach was being measured according to guidance.

- The trust had only recorded seven 12 hour trolley breaches over 2 December 2015 to 23 February 2016. The time in ED was not being measured in terms of the impact on patients. There were only five vulnerable patients (red patients) recorded as having patient bed moves including overnight from 1 September 2015 to 3 March. However, staff consistently told us they was pressure to move patients and vulnerable patients were being moved

Leadership of service

- Locally there were examples of good leadership. Medical leadership provided by the chief of service was supportive of medical and nursing staff and was aware of the pressures the department was under.
- The head of nursing for the department had been in post for less than three months. They had responsibility for the nursing leadership of the ED and the AMU.
- The staff in the department were supportive of each other as the department was often very busy and overcrowded. They told us they did not feel connected to the rest of the hospital that did not seem to be aware of the pressures in the ED.
- We found that there was not overall leadership of the emergency care pathway between ED and with medicine care services.
- Staff did not feel empowered to make decisions and make changes in their own department. . Senior medical leadership in the department had tried unsuccessfully for some considerable time to engage productively with the executive team to produce effective and necessary change. .
- The clinical leadership across the emergency care pathway had the right intentions. They had made attempts to engage with the executive team to improve the service but this had not amounted to significant progress. At the time of our unannounced inspection, the ED Chief of service, with other consultants, had previously arranged another meeting with the exec team which was to take place the next day. This meeting was to further discuss capacity issues and a workable and robust way forward.

Culture within the service

Urgent and emergency services

- The staff in the ED demonstrated a firm resilience. They were working under extreme pressures but were working hard to try to ensure patients received safe care.
- Staff described a culture of “learned helplessness” within the organisation and the level of increased risk had become normalised within the trust. They had learned to accept a standard of care that was unacceptable.
- Staff were tired and frustrated at a perceived lack of improvement with the business and overcrowding in the ED. Staff did not feel that they were engaged in planned changes to processes across the department and felt that the implementation of change was top down.
- Although there was a culture of openness in the department, staff told us that some safety incidents were not being reported as they had lost confidence that action would result from this. Staff felt that reporting was another task that they needed to undertake in an already critically busy department.
- Many staff identified that the behaviours of some staff in the department did not want to change. The trust had not identified improvement plans that focused on culture.

Public engagement

This was not inspected as part of the focused inspection.







Staff engagement

- Staff were working hard to assess and treat patients, but the department has been running over capacity for a prolonged period and staff were becoming weary. Staff told us that they did not feel engaged with proposed changes and finding solutions to problems.
- There was an acceptance among staff that the problems of the department could not be overcome.
- Staff were frustrated that they were not involved in decision making about the running of the department. They had also seen several improvement plans fail or be abandoned after a few days, leading them to the conclusion that nothing could change.
- Staff we spoke to expressed frustration about not being able to give patients the level of care they would like to. Morale among staff was affected when the department was struggling with capacity

Innovation, improvement and sustainability:

- Staff we spoke with identified “change fatigue” based on the trust introducing many “solutions” to the ongoing problem. There had been many changes to the emergency pathway which were not followed through. Staff described an environment an approach to improvement and innovation that was lacking in grip and pace.

Medical care (including older people's care)

Safe	Requires improvement	
Effective	Not sufficient evidence to rate	
Caring	Good	
Responsive	Requires improvement	
Well-led	Requires improvement	
Overall	Requires improvement	

Information about the service

We carried out this unannounced responsive inspection at The Queen Alexandra Hospital Portsmouth (part of Portsmouth Hospitals NHS Trust) on the 22 and 23 February 2016 and from 5pm to 2am on the 3 to 4 March 2016.

Prior to our inspection, we received information of concern about the trusts performance with its emergency pathway from the trust, NHS England, the Trust Development Authority (TDA) and the Emergency Care Improvement Programme (ECIP). There had been two risk summits held on 14 December 2015 and 28 January 2016. The risk summits had identified that escalation procedures had not been appropriately followed, and medical teams did not have general medical beds for admission. The hospital also had delays in discharging medically fit patients.

The purpose and focus of this inspection was to follow the urgent medical pathway for patients after they had been admitted from the Emergency Department in to the Medical Admissions Unit (MAU) and the wards.

The Queen Alexandra Hospital medical service as a whole had previously been inspected on the 10 to 13 February 2015. The medical service was rated overall as requires improvement.

This inspection:

On this inspection we visited all of the units in MAU. The units are designated by colours and are Pink, Lilac, Orange, Yellow, Red and Blue. We visited the winter

pressures ward E4 which was open until April 2016. We also visited a range of surgical and medical wards C5, C6, D2, D3, G1, G2, G3, G4, G9, G7, G6, F1, F2, F3, F4, D1, D5 and D6. We visited the escalation areas opened up in response to bed pressures. These were theatres recovery, cardiac day unit (CDU), the physiotherapy gym and the renal day unit. During our first visit two extra bed spaces had been created on D2 and D3 wards. We also visited the discharge lounge and attended three operational bed meetings.

During our inspection we spoke with 11 patients, five relatives and 46 members of staff, these included consultants, doctors, nurses, senior managers, ambulance staff, porters and domestic staff. We reviewed 35 patients' health care records. We reviewed the trusts performance information before, during and after our inspection.

Medical care (including older people's care)

Summary of findings

Overall we rated medicine as “requires improvement”. This is the same as our overall rating at our previous inspection in February 2015. Medical services were rated good for caring. However we rated safe, responsive and well led as requires improvement. We did not collect sufficient evidence to enable us to provide a rating for the effective domain.

Systems, processes and standard operating procedures were not always reliable, consistent or appropriate to keep people safe. There were some concerns about the consistency of understanding of staff in MAU with regards to infection control procedures. Medicines were not consistently stored securely in the MAU.

Care and treatment was inconsistent within the MAU. Some patients did not receive care based on assessment of risk or plans had not been developed to support identified risks. Patients did not consistently have changes in their condition escalated or responded to.

However, within all the other wards we visited, staff adhered to the trusts infection control procedures. Medications were stored securely and risks to patients were assessed, monitored and managed on a daily basis.

Most patients had assessments for pain throughout their hospital stay and the majority of patients had assessments for their nutritional needs and were supported to eat and drink if required.

Overall, staff had the necessary skills and competencies to provide effective care and treatment. However when some escalation areas were open, staff felt they did not always have the necessary skills to care for some patients.

Staff mainly responded compassionately when patients required help and support. We observed staff spent time talking to patients. We observed some kind, caring and personalised interactions. However, we witnessed one episode of poor care in MAU which we escalated to senior managers.

Patients were frequently moved which impacted on the timeliness of discharge. Some Patients had multiple bed moves and were moved at night. However, systems were in place which ensured medical outliers were tracked and reviewed on a daily basis.

Patients did not have access to timely discharge from hospital. Operational meetings did not identify reasons for the delays in patient discharge, or plans put in place to assess patients waiting for discharge. The discharge lounge was not fit for purpose. The lounge moved on a frequent basis, and was not suitable for patients who required beds. Staff were sometimes unaware of the location of the discharge lounge.

We noted several breaches of same sex accommodation in the escalation areas. However patients who were cared for on the wards had access to same sex facilities.

There were delays in the development of strategies designed to improve the urgent medical pathway. Senior staff described a dis-connect between themselves and directors. Changes in practice were frequently implemented but not always given sufficient time to be fully embedded or be evaluated.

The management of patient flow was fragmented and staff did not work together to ensure availability of beds. Some senior managers felt risks to patient care had been “normalised” and not responded to in a timely manner.

We observed clear medical and nurse leadership on the MAU. We observed positive interactions between staff and their immediate leaders in MAU and on the wards throughout our inspection.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement 

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

- Infection control practices were not consistently or appropriately followed on the MAU.
- Equipment on the MAU was not appropriately checked.
- Medicines were not consistently stored securely within the MAU.
- Records were not consistently stored securely within the medical service.
- Care and treatment was inconsistent within the MAU. All patients did not receive care based on assessment of risk or plans had not been developed to support identified risks.
- Patients did not consistently have changes in their condition escalated or responded to.
- Robust plans had not been developed to mitigate the risks to patient care in the event of a major incident.

However,

- Staff were reporting incidents.
- Risks to patients were assessed, monitored and managed on a day to day basis on the medical wards we visited. Changes to patients' conditions were identified and escalated appropriately.
- On the medical wards staff adhered to the trusts infection control procedures and medicines were stored securely.
- Staffing levels on the MAU and the medical wards were as planned.

Incidents

- All grades of staff we spoke with were aware of the incident reporting system and told us they were encouraged to report incidents. Most staff told us they received information via email or in team meetings about the outcome of the incident they reported.
- There was evidence of action and learning from incidents. For example, staff told us they completed incident forms when vulnerable patients were moved

from their wards. We saw from figures sent to us by the trust between September 2015 to March 2016 five vulnerable patients were moved from one ward to another.

Safety thermometer

- Not inspected as part of the focused inspection.

Cleanliness, infection control and hygiene

- Staff did not consistently adhere to the trusts infection control policies in the medical admissions unit (MAU).
- We observed many staff on the MAU not following infection control practices. For example, we observed a member of medical staff did not remove their gloves after leaving a patients room. The member of staff removed items of medical equipment from a trolley in a communal area whilst still wearing the gloves. The patient had an infectious condition and was cared for in an isolation room. There was a risk that the infection could be spread to other patients because the member of staff had not removed their gloves prior to touching the trolley.
- We observed another member of nursing staff did not remove their gloves after supporting a patient. They entered the patient's observations, whilst still wearing the gloves, on to the electronic recording system. The recording system was used by all staff.
- We observed soiled linen was left on the floor in a white plastic bag in the main corridor. There was a risk that the linen may have fallen out and contaminated the floor. A senior member of staff told us the linen should have been placed in a linen skip to prevent contamination.
- Wipes were available for patients to enable them to clean their hands. We observed these were not regularly offered to patients.
- We observed staff used gloves but not aprons when assisting patients with personal care. There was a risk cross infection because disposable aprons were not used.
- Staff were bare below the elbow and were seen washing their hands. However, they did not consistently use alcohol gels which were available at the entrance of all units and also in the corridors.
- All other medical ward areas were visibly clean and staff adhered to the trusts infection control policy.

Environment and equipment

Medical care (including older people's care)

- The environment was not consistently safe for patients in the MAU.
- We found the resuscitation trolley in Lilac unit was not checked daily as per the trust policy. Between 9 to 21 February 2015, daily checks to ensure equipment was available and in date had not been completed on the nine out of the 12 days.
- The suction machine on the resuscitation trolley in Lilac unit was due to be serviced in April 2015 We noted the machine had not been serviced to ensure it was safe for use.. We spoke with a member of staff who told us they did not know if the suction machine had been serviced. On our second visit we noted the suction machine had been serviced and was safe for use.
- Although it was noted that there was one hand washing sink, there were no washing facilities on Pink Unit. Patients were required to walk down a public corridor to access showers and toilets.
- Nursing staff on the MAU told us there were not sufficient cardiac monitors for patients who required them.
- All of the wards we visited had portable resuscitation trolleys. We saw daily checklists which documented all of the trolleys had been checked to ensure equipment was available and in date.
- Equipment was available, for example hoists and portable monitors, to support the delivery of care on the medical wards.
- During our second inspection we found there had been no improvement in the storage of medicines in both Lilac and Orange Units. We found medication was kept on the open shelves above the nurse's desk. Senior staff confirmed this medication should be stored securely to prevent unauthorised access.
- We found three medication charts were not dated and medicine administration records were not completed. Staff were unsure if the patients had received their medication.
- There was a large box designated for medication returns to pharmacy on Lilac unit. The box was full to overflowing. The box contained used intravenous medication lines, used gloves, empty infusion bottles and packaging from syringes. We spoke with staff who told us they did not know what the container was used for.
- One of the resuscitation trolleys was kept in the main corridor where staff could not consistently monitor it. This area was accessed by the general public. There were two boxes which contained medication used in the event of a cardiac arrest. The trolley was not tamper evident. There was a risk that the medication could be accessed by unauthorised personnel.
- Take home medication was electronically prescribed. Medical staff told us when medication had been prescribed the medicine charts were sent to the pharmacy department. However, this meant patients were not able to receive their medicine whilst still on the unit because the charts were in pharmacy.
- We found medication was stored securely on all of the wards we visited.

Medicines

- Medicines were not consistently stored correctly in the MAU
- During our first visit we found injectable medicine had been left in a communal corridor on Lilac unit in the MAU. We addressed our concerns to the nurse in charge and the medication was removed. We returned half an hour later and found further medication had been left out. We contacted the senior nurse who confirmed the medication should be stored securely.
- We found three bottles of intravenous paracetamol were stored on open shelves in the central area on Lilac unit.
- On Orange Unit we found large quantities of medication were left on an open shelf and were accessible to unauthorised personnel. These included patients own medication and medication to take home. Staff told us there was nowhere to store the medication. Although patient's bed side cabinets had locking facilities we were told by staff there were no keys available.

Records

- Records were not securely stored throughout the MAU and the medical wards we visited.
- We noted on the wards notes were kept in open and mostly unlockable trolleys in the main ward areas.
- We observed in the cardiology day unit (CDU) notes were kept on three unlocked trolleys in an unstaffed corridor whilst a patient clinic was in progress.
- On MAU patients' records were left in the corridor outside consulting room three. We also saw eight sets of patient's records in a public corridor.
- Patient records were mostly kept on shelves in central ward areas in MAU. There was a risk that patient records could be accessed by unauthorised personnel.

Medical care (including older people's care)

- All the records we reviewed on the wards contained relevant risk assessments for example pressure ulcer risk and venous thromboembolism (VTE) assessments

Safeguarding

- Not inspected as part of the focused inspection

Mandatory training

- Not inspected as part of the focused inspection

Assessing and responding to patient risk

- Patients received inconsistent care and treatment on MAU.
- Overall we reviewed 35 sets of patient records across the medical service. We found there were inconsistencies in the documentation and care plans in MAU. We found for some patients, care plans were not developed to meet identified risks and to ensure care was provided in a consistent manner. For example records for two patients showed they had grade two pressure areas. They did not have care plans or body maps (a chart to show location, size and number of injuries). One patient required dressings to their pressure ulcer. There was no information to instruct staff with regards to the type of dressing used. Staff told us they were unsure about which dressing should be applied.
- Another patient had two intravenous lines and a femoral line (a rapid and reliable route for the administration of drugs to the central circulation of the patient). These had not been recorded in the care plan and the lines were not regularly monitored to ensure they were safe for use. The patient was due for transfer to another area and although medical documentation was evident there were inconsistencies in the nursing observations and records. The patient became critically ill at 11.00 during the first day of our inspection. Initial nursing observations were recorded however no further observations were recorded from 12.00. The patient became ill again at 3pm. We observed nursing documentation was inconsistent and the patient's fluid intake and output was not monitored in a timely manner.
- There were no plans of care for six patients with indwelling urinary catheters to enable staff to care for them effectively.
- In other areas of MAU patients had assessments for the risk of pressure sores, however staff told us there was no

information to guide them with regards to the results of the assessments. This meant some staff were unsure of the processes followed if a patient was at risk of developing a pressure sore.

- However, in the Yellow and Blue units and throughout the wards we saw care plans had been developed and documentation fully completed to ensure patients' received consistent care.
- Nursing staff completed the electronic early warning scoring system (EWS). The scoring system enabled nurses to assess patient's observations and provided protocols to follow if the observations varied from the patient's norm. Whilst some staff responded promptly to changes in a patient's condition this was not consistent across MAU. For example we saw in Yellow unit two patients were consistently scoring highly on the EWS system. Staff told us this was because they scored higher than average normal readings because of their medical condition. We saw in the patient's records that the readings had not been escalated to medical staff. Staff told us this because they were experienced and knew what to look for. However, there was a risk that any change in the patient's condition may not have been identified and escalated to medical staff. We saw for another patient in Yellow unit staff had not responded to a change in a patient's EWS readings. The patient had scored highly at 01.55 and no further observations were recorded until 03.44. Further observations were taken at 05.17 and 07.55 all of which scored highly. We could find no evidence that these readings had been reported to medical staff. A member of staff told us the doctors should have been told and confirmed there was no documentation to support the observations had been escalated to medical staff.
- We observed in patient's records across the medical wards that any changes in EWS had been identified and escalated to medical staff when appropriate.
- Staff on the medical wards told us patients were assessed for risk with regards to movement to another ward. This took the form of a red, amber, green (RAG) rating, with red patients assessed as being unsuitable to move. Staff consistently told us there was pressure from senior managers to move patients assessed as red, and they were moved.

Nursing staffing

Medical care (including older people's care)

- Staff employed by the trust were designated to work in escalation areas. Senior managers told us this was to ensure patients received care from staff who knew the systems and processes of the hospital.
- Staff from a variety of wards worked on the winter pressures ward (E4). Staff remained on the ward whilst it was open to ensure continuity of care for patients.
- Allocation for staff in MAU was conducted on a daily basis. A daily morning meeting took place which assessed the acuity of patients. Staff were allocated to units on the basis of their skills and experience. Staff told us they could work anywhere within the MAU. However, they told us because they may not work consecutive days in the same unit, this may impact on the continuity of care for some patients. Staffing rotas demonstrated that there was a sufficient number of nursing staff to care for the patients in the MAU.

Medical staffing

- Speciality medical doctors did not review their patients in a timely manner. Patients had been referred to them via the emergency department. Medical staff told us there was not sufficient specialist medical staff to ensure all patients on the wards, in MAU and in the emergency department were reviewed.
- Handovers were conducted for medical staff. This included a post take doctors meeting. The meeting was attended by a variety of specialities which included respiratory, elderly and MAU consultants plus junior doctors. Each specialities patients were identified and allocated to junior doctors for assessment.
- During our out of hours inspection there was one consultant of the day, three senior doctors and one house officer on duty overnight in MAU.
- Overall the medical service had 10 acute consultant physicians of which seven consultants are part of the on-call rota at night.

Major incident awareness and training

- Senior managers told us they had conducted a table top exercise to enable them to plan for a major emergency. However, they stated that sufficient emphasis had not been given to the likely increase in demand for the Emergency Department(ED) and across the medical

service in the event of a major incident. Plans had not been developed which ensured patients' were discharged in a timely manner to ensure the availability of beds in the hospital and treatment spaces in the ED.

Are medical care services effective?

Not sufficient evidence to rate

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

We did not collect sufficient corroborated evidence to enable us to provide a rating for the effective domain.

- Patients in MAU nutritional assessments had not been completed. On one ward we saw that patients were not consistently supported to eat and drink.
- When some escalation areas were open staff felt they did not consistently have the necessary skills to care for some patients.
- Most patients had assessments for pain throughout their hospital stay.
- The majority of patients had assessments for their nutritional needs and were supported to eat and drink if required.
- Overall staff had the necessary skills and competencies to provide effective care and treatment.
- People received care from a range of different staff, teams or services. The teams worked collaboratively and care was co-ordinated.

Evidence-based care and treatment

- Not inspected as part of the focused inspection.

Pain relief

- Overall, patient records demonstrated that patients had on-going assessments for pain throughout their stay. However, a relative raised concerns in MAU about a patient who was in pain. We saw that no pain control had been prescribed. We raised our concerns with staff who ensured pain control was prescribed and given to the patient.

Nutrition and hydration

Medical care (including older people's care)

- The majority of patients across the medical service had their nutritional status assessed using the Malnutrition Universal Screening Tool (MUST). Referrals were made to the dieticians if a patient required further support with their nutrition. However we saw inconsistencies in the completion of the assessments in MAU. We saw in 9 records the assessments had not been completed.
- We observed on the first day of our inspection that patients on E4 (winter pressure ward) that although red trays (used to identify patient who require nutritional support) were available, we saw instances of patients not always being supported with their meals to ensure they received adequate food and fluids. One patient was served a hot evening meal. We observed a member of domestic staff took away the tray still untouched and the meal had gone cold. We spoke with the member of staff who told us the patient had said to take it away. We observed the patient was confused and distressed and may have required support and encouragement to eat and drink.
- Another patient was lying in bed with their meal left on the locker out of reach. The meal had gone cold and a member of domestic staff told us the patient required help and "there's no one to help them".
- We observed the use of the red tray system on the other wards we visited and observed that patients were consistently supported to eat and drink.

Patient Outcomes

- Not inspected as part of the focused inspection.

Competent staff

- Overall staff in the medical service had the necessary skills and competencies to provide effective care and treatment. However, staff in the coronary day unit (CDU) were at times required to look after patients with respiratory illnesses when the department was open for escalation. They told us they felt they did not have the necessary skills to care for these patients. There was a selection criteria for patients admission to CDU, this was to ensure only patients the staff were competent to care for were admitted. They told us at times and especially out of hours the criteria was not consistently adhered to.
- Theatre staff told us there were times when medical patients had been cared for overnight in recovery. They told us they felt they did not have the necessary skills to care for medical patients.

Multidisciplinary working

- We observed members of community teams visited some patients within the MAU. This was to ensure plans were in place to ensure timely discharge home.
- From our review of records and discussions with staff we saw there was evidence of multi-disciplinary team (MDT) working practices. For example physiotherapists and occupational therapists had documented their input into patients care. We also saw patients had been reviewed by mental health services when required.

Seven-day services

- Patients had full access to diagnostic services out of hours.

Access to information:

- Not inspected as part of the focused inspection.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Throughout our visits staff we spoke with were clear about their roles and responsibilities regarding the Mental Capacity Act (2005). They were clear about processes to follow if they thought a patient lacked capacity to make decisions about their care.

Are medical care services caring?

Good



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

- Overall staff responded compassionately when patients required help and support. We observed staff spent time talking to patients.
- We observed kind caring interactions.
- Most of the patients we spoke with told us they had sufficient information about their care.

However

- We observed one episode of poor care in MAU. We escalated this to senior managers.
- Three patients in MAU told us they did not have information about the reason for their delays in discharge.

Medical care (including older people's care)

Compassionate care

- Overall we observed throughout our visit that patients were treated with respect and dignity. Curtains were drawn around patients when personal care was delivered.
- However we witnessed poor care for one patient in MAU during our out of hour's inspection. We raised our concerns with the senior nurse in charge. We were assured the member of staff would be moved and the patient cared for in an appropriate manner. On our return to the unit, the member of staff had been removed and the patient was comfortable and settled.
- We witnessed compassionate care on the medical wards. Relatives were given time to ask questions and patients were cared for in a respectful and kind manner.
- We observed a substantially good episode of care where a passing Emergency Medicine Assistant (EMA) stopped to help a distressed patient on Orange Unit. He had heard the patient call out for help, stopped what they were doing and went to the bedside to assist the patient to find their belongings. The porter ensured the patient was comfortable and had their buzzer before they left.

Understanding and involvement of patients and those close to

- Most of the patients' we spoke with told us they had enough information about their care.
- Three patients who were waiting for discharge home in the MAU told us they had not been given information about the delay in their discharge.

Emotional support

- We witnessed staff offered appropriate emotional support to patients throughout the wards we visited.

Are medical care services responsive?

Requires improvement



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

- Operational improvement plans to reduce overcrowding and improve patient flow had only recently been planned to start in March and April 2016.

- Patients did not have access to timely discharge from hospital. Operational meetings did not identify reasons for the delays in patient discharge, or plans put in place to assess patients waiting for discharge.
- Patients were frequently moved which impacted on the timeliness of discharge. Patients had multiple bed moves and were moved at night.
- The discharge lounge was not fit for purpose. The lounge moved on a frequent basis, and was not suitable for patients who required beds. Staff were sometimes unaware of the location of the discharge lounge.
- We noted several breeches of same sex accommodation in the escalation areas.

However,

- All patients on the wards had access to same sex facilities
- Staffing had been planned to ensure patients had continuity of care on E4 (winter pressures ward) and in the escalation areas.
- Systems were in place which ensured medical outliers were tracked and reviewed on a daily basis.

Service planning and delivery to meet the needs of local people

- The trust improvement plan 2016/17 was being developed to address overcrowding and problems with patient flow. The initiatives in medicine included a new medical model for admission, a short stay model of care, a frailty intervention team and GP heralded patients to the MAU. Having been identified and discussed at risk summits in December 2015 and January 2016, these initiatives had not yet started and were being planned in three phases in March, April and June 2016.
- GP heralded patients were planned to be admitted through the medical assessment unit rather than the emergency department. This was planned start date was 2 March 2016. During our unannounced inspection we saw evidence of GP heralded patients to the MAU but this was happening inconsistently and many patients were still going through the ED.
- During our visit the trust had opened escalation areas to meet the needs of people who were being admitted through the emergency department. These areas were theatre recovery cardiac day unit (CDU), physiotherapy gym and the renal day unit. During our first visit two extra bed spaces had been created on D1 and D2 wards.

Medical care (including older people's care)

Access and flow

- During our unannounced inspection we observed three bed meetings. There were 20 staff representing each of the Clinical Service Centres (CSCs) these included matrons and business managers. Senior managers told us the meetings provided a forum for bed escalation; however we observed each CSC worked independently and there was no cohesive planning which assessed the hospital bed availability as a whole.
- We observed the GP Heralded patients (a service which commenced 2 days previously) was not discussed or included in the planning.
- Medical staff in MAU told us the system for discharging patients was not electronic. They were required to manually write discharge information. They told us this impacted on the timely discharge of patients.
- A system to monitor all medical outliers had been developed. Most of the medical staff we spoke with was confident that the system worked and they were able to ensure their patients were reviewed on a daily basis. Ward staff confirmed on the whole any outliers on the ward were reviewed daily. However, they commented that the reviews often happened later during the day which impacted on the timeliness of patient discharges.
- The trust was introducing an IT system to ensure patients and their consultant could be appropriately tracked in the hospital.
- Staff across the service consistently told us patients had multiple bed moves. For example we shown documentation that one patient had been moved five times during their hospital stay.
- Staff told us patients were often moved at night. We met with senior managers for one clinical service unit. They told us 13 patients had been moved overnight for non-clinical reasons. 10 of which had been moved between nine and midnight. The remaining three patients were moved after midnight. They told us there was a further nine CSCs each of whom may have had further patients that had been moved overnight.
- Theatre staff told us the recovery area had been opened up "frequently" for patients overnight. The area had been identified as a suitable place for surgical patients overnight. However, they told us they had received medical patients and one patient had been admitted to recovery directly from the emergency department and had not been assessed by a medical team. Senior staff told us "most of the issues happen at night".
- During our announced inspection, the hospital reported that there were between 90 and 150 patients that were medically fit and awaiting discharge. When discharge delays over 24 hours were removed from this number, there were 50 simple discharge delays and transfers of care.
- On our unannounced inspection there were 195 patients awaiting discharge. This included 18 patients who were waiting for physiotherapy, 20 patients who required a package of care and 30 patients who required further medical intervention. Eight patients were waiting for a nursing home bed and a further nine patients were waiting for a bed on a rehabilitation ward. For 88 patients, discharges had been indicated but no further steps had been noted. Senior staff told us at the time of the inspection there was no overall monitoring of planned discharge dates in order to prevent patients from having an extended stay in hospital. Only patients who had been in the hospital over 14 days were reviewed. They told us there were plans to review patients discharge earlier in their stay however this was yet to start. One member of medical staff told us "patients are stuck because the processes are unclear.
- Senior managers told us there was often a delay to patients discharge because they had been moved. Patients assessed as green (usually patients who were ready for discharge) were often moved to other wards. They told us this often created delay because information about the patient's plans for discharge was often not communicated when the patient was moved. For example a medical patient who was ready for a nurse led discharge the following day had been moved to a surgical area overnight. Senior managers told us they needed to ensure the surgical staff had the necessary information to ensure the patient was discharged as planned during the day.
- The discharge lounge was open from 8.00am to 7.30pm Monday to Friday and 9.00am to 5pm at weekends. Nursing staff told us the discharge lounge moved on a regular basis. On our first inspection the discharge lounge was situated in a training room. On our out of hours inspection the lounge was in a room located close to the gynaecology ward. On both occasions the areas could not accommodate patients who required a bed. Staff told us if a patient required a bed they were required to wait on the ward until transportation was available to take them home. They told us this had an impact on the amount of beds available on the wards

Medical care (including older people's care)

for patients who required admission to hospital. On our out of hours inspection there were signs in the main entrance to inform staff, relatives and ambulance crews of the location of the discharge lounge. We spoke with two ambulance crew who told us the signs were not always displayed and there were times when they were unable to locate the patients they had come to collect.

Meeting people's individual needs

- We observed patients were not consistently cared for in same sex accommodation in the escalation areas.
- On the cardiac day unit there was one shower and three toilets. The ward was shared by men and women. We saw a female patient was in a bed with an empty bed between them and a male patient. Staff told us they tried to use a screen but this was not always effective.
- When the renal day unit is opened as an escalation area, the single sex arrangements are managed by having each side of the day unit as single sex divided by screens to maintain privacy and dignity. The toilet facilities within the day unit are maintained as single sex and the toilet facilities just outside of the unit are used for the opposite sex. The trust had identified that this avoided single sex accommodation breaches. However, staff on the renal unit told us the mitigating actions did not always protect the privacy and dignity of patients and this was a concern as sometimes facilities were shared.
- Staff in theatre recovery told us when the area was opened up for patients overnight, they tried to ensure men and women were placed in different areas with curtains drawn around them. There was no access to showers or wash hand basins in the immediate vicinity; however, if patients required hand washing facilities staff will provide disposable bowls and hand towels. There is an allocated toilet and washing facilities for patients within the theatre complex.
- Throughout the rest of the areas we visited patients had access to single sex facilities.

Learning from complaints and concerns

- Not inspected as part of the focused inspection.

Are medical care services well-led?

Requires improvement 

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

- There were delays in the development of strategies designed to improve the urgent medical pathway.
- The trust improvement plan had not been communicated effectively with staff and there were already some delays in its planned implementation.
- Senior staff described a disconnect between themselves and directors. Changes in practice were frequently implemented but not given sufficient time to be fully embedded or evaluated.
- Senior managers felt risks to patient care had been “normalised” and not responded to in a timely manner.
- The management of patient flow was fragmented and staff did not work together to ensure availability of beds.

However.

- We observed clear medical leadership on the MAU.
- There was visible senior nurse leadership on MAU and on the medical wards we visited.
- We observed positive interactions between staff and their immediate leaders in MAU and on the wards throughout our inspection.

Vision and strategy for this service

- Senior hospital managers had developed a strategy to improve the urgent medical pathway. A summary of the progress for delivery of the improvement plan was presented at the risk summit held on 27 January 2016. These plans included the development of a short stay medical model and a frailty and interface team. The purpose of the short stay medical model was to identify patients who were only required to stay in hospital for a short time (< 72 hours). The short stay medical model would be in place on 15 February 2016 but this had not happened as planned and had been revised to April 2016.
- The trust developed a revised improvement plan 2016/17 indicated the new phases of development.

Medical care (including older people's care)

- Ensuring the ED was used appropriately
- Preventing unnecessary attendance and admission
- Introducing a frailty intervention team
- A new medical model for speciality teams seeing medical patients on the day of admission simplifying the approach to medical take
- Geographically based care – where all patients on a ward are the responsibility of that speciality team unless it is in the best interests of the patient to transfer their care to another speciality team
- Estimated date of discharge set on admission by frailty or medical consultants teams.
- Increasing the identification and management of short stay medical take patients to the national average of 65% through a short stay model of care.
- The improvement plan 2016/17 had three phases and would be introduced by June 2016. The new medical model of care in medicine where medical emergency patients were admitted and seen by acute and specialist physicians as general medical admissions was being introduced in three phases in March, April and June 2016. There had been discussion between the trust and consultants to introduce this model. However, many staff indicated that some speciality consultants were not engaged or committed to changing the medical model of care.
- Staff identified that the trust had not managed the emergency pathway changes appropriately (this was the third model for emergency flow in the last 12 months), and there would be delays in implemented changes effectively.
- The frailty and interface team was designed to bring together consultants, nurses and therapists to address the high level of frail patients admitted. Whilst the recruitment of this team was on target, the team would not be fully in place until 1 April 2016.

Governance, risk management and quality measurement

- Some managers told us that they felt the risks to patient's had increased because of the pressures on the hospital. They also told us they felt there had been a "normalisation" of the risks. They told us they regularly presented their concerns at risk meetings. However, they felt that senior managers had not acknowledged their concerns.

- Quality measurement had not yet been developed for the planned for the improvements in the urgent medical pathway. This meant the service had not devised a system where they could measure or compare the quality of the service they intended to provide.

Leadership of service

- Senior hospital managers did not have oversight of the service as a whole. We observed in bed meetings that managers did not ensure staff worked together or forward planned to ensure the future availability of beds.
- We were told there was variable leadership from medical consultants throughout the trust. One member of senior medical staff told us "some more than others" were involved in engaging with plans for future change. We found that general physicians were not engaged with acute medicine.
- Senior medical staff told us frequent changes in practice were developed from "above", (Senior medical staff and the executive team) They told us the plans were not complete and they were not given time for the change in practice to be evaluated or fully embedded. They described a "change fatigue" and stated "we are doing all we can".
- We saw clear local medical leadership on MAU.
- There was clear and visible senior nurse leadership on the wards we visited.

Culture within the service

- Some managers told us they felt there was a dis-connect between themselves and some senior medical and executive staff. They told us they felt excluded from plans for their service. For example they felt they had not been included in the plans for the development of the short stay medical model and for the reduction of medical outliers across the trust.
- Ward staff consistently told us there were times when they felt undue pressure from Patient Flow Managers
- They told us "it can be difficult when junior staff are working because they (bed managers) put a lot of pressure on them to move patients.
- During our visit we observed staff interactions with each other and their immediate managers on the wards and in MAU. We saw that staff treated each other with respect and they were able to speak freely with managers.

Medical care (including older people's care)

Public engagement:

- Not inspected as part of the focused inspection

Staff engagement:

- Some senior medical staff told us they had not been consulted in the further development of escalation plans. They told us they felt the plans were not robust and the use of escalation areas had been “normalised”.
- Many staff told us that changes were not effectively communicated. Some staff were unaware of when changes had been agreed or introduced and often this had led to changes not working or being implemented badly. Staff described reverting to previous styles of working or behaviours.

- Staff were not aware of the trust improvement planning process.

Innovation, improvement and sustainability:

- Staff we spoke with identified “change fatigue” based on the trust introducing many “solutions” to the ongoing problem. There had been many changes to the emergency pathway which were not followed through. Staff described an environment and approach to improvement and innovation that was lacking in grip and pace.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

The trust must take immediate action, to ensure

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

The trust MUST ensure

- Patients waiting in the corridor, or in ambulance vehicles, must be adequately observed and monitored by staff appropriately trained staff.

- The hospital must accept full clinical responsibility for patients waiting on the ambulance apron
- The safe storage of medicines in the MAU.
- Patients are cared for in single sex facilities in the escalation areas.
- Patient notes are stored securely across the hospital to prevent unauthorised access.
- All patients in MAU have care based on plans developed to support identified risks.
- Patients receive timely discharge from hospital.
- Plans to change the urgent medical pathway are implemented in a timely manner.
- Staff in the MAU adhere to infection control policies and procedures
- There is better and more accurate monitoring information to reflect patient safety and the quality of care

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

Treatment of disease, disorder or injury

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

(1) (2) (a) ensuring the privacy of the service user.

- People did not consistently have access to single sex accommodation in the escalation areas.

Regulated activity

Regulation

Treatment of disease, disorder or injury

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

(1) (2) (a) (b) (c) (g) (h).

- Patients attending the Emergency Department at Queen Alexandra Hospital are not triaged, assessed and streamlined by appropriately trained staff and escalation procedures are not followed.
- Patients waiting in the corridor, or in ambulance vehicles, were not adequately observed or monitored by appropriately trained staff.
- Medicines were not consistently stored securely in the MAU.
- Assessments, planning and delivery of care was not always based on risk assessments and staff must follow plans and pathways
- Patients in MAU did not all have care based on plans developed to support identified risks.
- Patients did not always receive timely discharge from hospital.
- Staff in the MAU did not always adhere to infection control policies and procedures.

Regulated activity

Regulation

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

(1) (2) (a) (b) (c) (e).

The following were not appropriately assessed, monitored or improved.

- There needed to be appropriate leadership of the emergency care pathway.
- The “Jumbulance” should not be used in terms of patient safety and experience.
- The trust required better and more accurate monitoring information to reflect patient safety and the quality of care
- The trust had not accepted clinical responsibility for patients waiting on the ambulance apron
- Notes should be kept secure at all times and only accessed by authorised people. Throughout the hospital notes were not consistently stored securely.
- Plans to change the urgent medical pathway were not being implemented in a timely manner.

Enforcement actions

Action we have told the provider to take

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

Regulated activity

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

Regulation

Section 31 HSCA Urgent procedure for suspension, variation etc.

We issued a s31 Notice of decision to urgently impose conditions on the registered provider as we had reasonable cause to believe a person would or may be exposed to the risk of harm unless we did so. The notice of decision was in respect of Queen Alexandra Hospital, Portsmouth NHS Trust.

- 1. The Registered Provider must ensure there is effective leadership of the emergency care pathway. There should be a clinical transformation lead that is appointed based on external advice and agreement. The lead should have the authority to make decisions, and ensure there is swift and appropriate action in relation to identified problems. There should be effective leadership, resource and support of the trust improvement plan to ensure changes are appropriately supported and implemented at pace. The trust improvement plan should be adhered to and any deviation must be based on external advice and agreement. Medical and nursing leadership, that is specific to the emergency department, should be clearly identified and supported, so that staff are empowered to make and act on decisions in the interest of patient care and safety.**
- 2. The Registered Provider must operate an effective escalation system which will ensure that every patient attending the Emergency Department at Queen Alexandra Hospital is triaged, assessed and streamlined by appropriately qualified staff as set out in the guidance issued by the College of Emergency Medicine and others in their Triage Position Statement. April 2011 The trust should follow**

Enforcement actions

the escalation procedures identified to manage increases in demand and pressures on the emergency pathway. The escalation process should be defined based on external advice and agreement. The actions the trust should take should be responsive and should not be delayed.

- 3. The registered provider must ensure the large multi-occupancy ambulance known as the “Jumbulance” will not be permitted to be used on site at the Queen Alexandra Hospital. The exception to this will be if a major incident is declared. If the vehicle is then used, there should be appropriate action taken to ensure patients are kept safe at all times. The Registered Provider must ensure that ambulance waits do not exceed the recognised national target.**
- 4. The Registered Provider must provide CQC with daily monitoring information that is to be provided on a weekly basis.**

- % of ambulance arrivals assessed within 15 minutes; indicate % >30 minutes and % > 60 minutes. Identify the longest waiting times (> 60 minutes), clinical details and reasons for long wait
- % of ambulance patients treated within 60 minutes; indicate % > 2 hours, % > 3 hours. Identify the longest waiting times (> 3 hours), clinical details and reasons for long wait
- % of patients (type 1) meeting the national emergency access 4 hour target
- % of patients waiting to be admitted 4 – 6 hours; > 6 hours; > 12 hours; >24 hours
- Number of 12 hour trolley breaches based on a decision to admit within four hours of admission (if the emergency access target is to be met)
- Number of ambulance delays > 30 minutes and > 60 minutes.
- Number of times 4 or more ambulances are waiting over 30 minutes outside the emergency department - frequency and duration. This should also be identified as an incident
- Number of patients to ambulatory emergency care pathway
- Number of patients to the Urgent Care Centre.

This section is primarily information for the provider

Enforcement actions

- Number of medical outliers
- Number of escalation beds in use
- Number of patient bed moves for non-clinical reasons. Patient moving > 2, >3 or more times. Identify number of times vulnerable patients (frail elderly or end of life care patients) have been moved within these figures.
- Number of patient bed moves over night. Appropriately identify number of times vulnerable patients (frail elderly or end of life care patients) have been moved within these figures.
- Number of emergency medical patients whose length of stay is between 1 – 2 days. Number of patients delayed discharged who are medically fit: delays 24 hours; > 1 – 2 days; > 2 – 7 days; > 7 days. Reasons for delay.
- Number and details of incidents reported in ED and MAU - all near misses, low, moderate and severe harm.
- Assurance report on the quality of data and the level of incident reporting