Care Quality Commission

Portsmouth Hospitals NHS Trust

Queen Alexandra Hospital

Quality Report

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

Ratings

Urgent and emergency services	Not sufficient evidence to rate ●

Summary of findings

Letter from the Chief Inspector of Hospitals

This was a focussed, unannounced inspection of the emergency care service at Queen Alexandra Hospital. This inspection took place on 25 February 2019. We have not inspected all key lines of enquiry and so we have not issued any revised ratings of the urgent and emergency care service at this time.

Our key findings were:

We found there to be very limited clinical leadership of the emergency department, and in particular, the pit-stop area and ambulance reception area until the departmental Clinical Lead assumed control at approximately 16:00.

At times, we observed patients being handed between five different nurses with no clinical interventions occurring. These multiple handovers do introduce an element of risk for patients.

The nurse-in-charge was observed undertaking a range of task orientated activities including the physical movement of trolleys and patients; this distracted them from managing the emergency department and likely impacted on the poor flow across the emergency pathway.

Majors B lacked any noticeable senior clinical leadership; oversight of flow was by way of a band four associate practitioner (Nursing). Patients experienced delays in discharge because of a lack of suitably competent staff or the availability of equipment.

Flow through the pit-stop process was slow and at times became stagnated. There was confusion as to the purpose of the area with some patients receiving extended levels of care, again despite other patients waiting in the department for their treatment to commence. Again, there lacked any noticeable clinical leadership of the area which impacted on the smooth flow of patients through the emergency pathway.

The waiting room did not have sufficient seating to accommodate patients during peak times. Patients and visitors were observed standing for extended periods because of a lack of seats. We noted the streaming nurses to be competent at undertaking initial assessments. Patients did however experience delays in their care commencing, in part because of a congested emergency department. Patients also experienced delays in being initially assessed by the streaming nurse. There was a lack of robust assurance to support the effectiveness of the streaming pathway.

Hand hygiene practices and compliance remained poor with very limited hand decontamination taking place during the inspection.

There were occasions when the privacy and dignity of patients was not protected. During feedback we provided examples of occasions when nursing staff had failed to cover patients up; instead opting to half close cubicle curtains. Frail elderly patients were left for periods of time in Majors with no access to call bells, and left in unacceptable states of undress.

Patients were observed being moved through the department without being spoken to; staff routinely released the brakes on trolleys and started moving patients. Again, this was a common observation; it showed little in the way of positive communication between patients and staff.

However,

New bereavement facilities were a significant improvement on the facilities which had been found to be lacking at previous inspections.

Summary of findings

The improvement board, located in the department, was observed to be well used with encouraging signs the views and voices of staff were being considered and heard respectively. There was a sense amongst staff we spoke with of improvements in relationships between the trust leadership team and staff working in the emergency department. Staff reported members of the executive team to be highly visible and supportive during times of surge.

The introduction of dedicated training time was welcomed by junior doctors across the department. The protected rostered non-clinical time for consultants to provide dedicated training on a weekly basis will be of great benefit to trainee doctors.

The use of the Hospital and Ambulance Liaison Officer (HALO) to oversee and co-ordinate the arrival of ambulances during times of surge, and the working relationships between the local NHS ambulance trust and Portsmouth Hospitals NHS Trust seemed robust. We observed good working relationships between ED staff and ambulance staff. There was clear prioritisation of patients who remained "On-board" ambulances due to limited capacity in the emergency department.

The service maintained a risk register which recorded known risks and rated them according to their potential impact. The risk register reflected the risks spoken about by staff in the department. The risk register further acknowledged the challenges inspectors identified during the inspection. There was a sense the leadership team were more aware of the challenges they faced than was the case in the previous inspection.

A range of staff including doctors, nurses, support workers, administrative staff and representatives from the local NHS ambulance trust reported they were able to raise concerns to local the management team without fear of retribution. Staff told us they felt supported and were encouraged to be open and transparent. There was an appetite among staff to improve the quality of care provided in the department.

Health professionals reported good multi-disciplinary working with positive relationships existing between doctors and nurses for example.

Many staff described their work colleagues as their second family and told us they would not want to work anywhere else. This continued to be the case at this inspection despite the department having experienced very busy periods over the preceding weeks.

Dr. Nigel Acheson

Deputy Chief Inspector of Hospitals

Queen Alexandra Hospital

Detailed findings

Services we looked at
Urgent and emergency services

Detailed findings from this inspection

Urgent and emergency services

Safe	**Not sufficient evidence to rate**	●
Caring	**Not sufficient evidence to rate**	●
Responsive	**Not sufficient evidence to rate**	●
Well-led	**Not sufficient evidence to rate**	●
Overall	**Not sufficient evidence to rate**	●

Information about the service

Queen Alexandra Hospital is the acute district general hospital of the Portsmouth Hospitals NHS Trust. The emergency department (ED) 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 emergency department is a recognised trauma unit. Major trauma patients are transported directly to the nearest major trauma unit.

The department has a four-bay resuscitation area, with one bay designated for children.There are two major treatment areas; majors A has 18 bays and three cubicles, majors B has six bays and four chairs (with a trolley for clinical examination). There is a separate 'pit stop' assessment area with six trolleys and four chairs. In the event that the pit stop area is full, up to six patients are accommodated in the corridor while they wait for assessment. One further corridor area is used when the department reaches capacity. There is a nine-bed emergency decision unit (EDU). This area comprises two four-bed bays and a single-bed side-room. The area is used for patients who are unlikely to require admission but who require short term observation or are waiting for test results. The unit is regularly used to accommodate patients with acute mental health problems who are waiting for assessment by a mental health practitioner or waiting for a mental health bed.

There is a sideroom designated for mental health practitioners to undertake mental health assessments. The unit also accommodates frail elderly patients. The minor treatment area has six treatment cubicles and two consultation rooms used by general practitioners to provide an urgent care service. This service operates from 8am to 11pm, seven days a week and sees patients who present with a condition which requires immediate treatment, but which can be carried out by a GP.

The emergency department has a separate children's treatment area with its own secure waiting room. This consists of an observed play area, a high dependency cubicle, an isolation room, five majors cubicles and four minors cubicles. This area is open from 7.30am until 2am, seven days a week. Outside of these hours, children are seen in the main (adult) area of the emergency department or they are taken directly to the children's assessment unit, located elsewhere in the hospital.

A purpose built Frailty Assessment Unit opened in January 2019. This facility provides ten care spaces for frail patients, who are unlikely to require admission, but may require multi-disciplinary input.

A new, purpose built, bereavement suite has been in use since January 2018. This suite provides a dedicated and private space for relatives to say farewell to their loved one and grief in private.

Urgent and emergency services

Summary of findings

We did not inspect the whole core service therefore there are no ratings associated with this inspection.

Our key findings were:

At times, we observed patients being handed between five different nurses with no clinical interventions occurring. These multiple handovers do introduce an element of risk for patients.

We found there to be very limited clinical leadership of the emergency department, and in particular, the pit-stop area and ambulance reception area until the departmental Clinical Lead assumed control at approximately 16:00.

The nurse-in-charge was observed undertaking a range of task orientated activities including the physical movement of trolleys and patients; this distracted them from managing the emergency department and likely impacted on the poor flow across the emergency pathway.

Majors B lacked any noticeable senior clinical leadership; nursing oversight was by way of a band four health professional who was not able to administer intravenous medicines. Patients experienced delays in discharge because of a lack of suitably competent staff or the availability of equipment.

Flow through the pit-stop process was slow and at times became stagnated. There was confusion as to the purpose of the area with some patients receiving extended levels of care, again despite other patients waiting in the department for their treatment to commence. Again, there lacked any noticeable clinical leadership of the area which impacted on the smooth flow of patients through the emergency pathway.

The waiting room did not have sufficient seating to accommodate patients during peak times. Patients and visitors were observed standing for extended periods because of a lack of seats. We noted the streaming nurses to be competent at undertaking initial assessments. Patients did however experience delays in their care commencing, in part because of a congested emergency department. Patients also experienced delays in being initially assessed by the streaming nurse. There was a lack of robust assurance to support the effectiveness of the streaming pathway.

Hand hygiene practices and compliance remained poor with very limited hand decontamination taking place during the inspection.

There were occasions when the privacy and dignity of patients was not protected. During feedback we provided examples of occasions when nursing staff had failed to cover patients up; instead opting to half close cubicle curtains. Frail elderly patients were left for periods of time in Majors with no access to call bells, and left in unacceptable states of undress.

Patients were observed being moved through the department without being spoken to; staff routinely released the brakes on trolleys and started moving patients. Again, this was a common observation; it showed little in the way of positive communication between patients and staff.

However,

New bereavement facilities were a significant improvement on the facilities which had been found to be lacking at previous inspections.

The improvement board, located in the department, was observed to be well used with encouraging signs the views and voices of staff were being considered and heard respectively. There was a sense amongst staff we spoke with of improvements in relationships between the trust leadership team and staff working in the emergency department. Staff reported members of the executive team to be highly visible and supportive during times of surge.

The introduction of dedicated training time was welcomed by junior doctors across the department. The protected rostered non-clinical time for consultants to provide dedicated training on a weekly basis will be of great benefit to trainee doctors.

The use of the Hospital and Ambulance Liaison Officer (HALO) to oversee and co-ordinate the arrival of ambulances during times of surge, and the working relationships between the local NHS ambulance trust and Portsmouth Hospitals NHS Trust seemed robust.

Urgent and emergency services

We observed good working relationships between ED staff and ambulance staff. There was clear prioritisation of patients who remained "On-board" ambulances due to limited capacity in the emergency department.

Are urgent and emergency services safe?

Not sufficient evidence to rate ●

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

Environment and equipment

- We had previously reported crowding within the ambulance entrance posed a risk to the safety of patients. At this inspection, the emergency department was frequently crowded.We saw patients frequently queued in the corridor inside the ambulance entrance. This was a confined space and frequently became congested, hampering the movement of patients, staff and equipment. The area was not designed or equipped for patients. There were no call bells or piped oxygen in this area. Patient flow across the emergency department was poorly managed, in part because of the multiple tasks being undertaken by the designated nurse-in-charge which distracted them from providing a command-and-control ability, and also because of the poor layout of the department hindering effective communication. The trust acknowledged the environment was not suitable for providing modern emergency healthcare. The trust reported they had been successful in securing capital funding to redevelop the emergency care department. This was being driven via the Portsmouth Hospitals NHS Trust Emergency Floor Reconfiguration Project.

- The emergency department comprised of a four-bay resuscitation area, with one bay designated for children.There were two major treatment areas; majors A which had 18 bays and three cubicles; and majors B which had six bays and four chairs (with a trolley for clinical examination). There was a separate 'pit stop' assessment area with six trolleys and four chairs. The department had a a nine-bed emergency decision unit (EDU) which comprised of two four-bed bays and a single-bed side-room. The area was used for patients who were unlikely to require admission but who required short term observation or were waiting for test results. The EDU was regularly used to accommodate patients with acute mental health problems who were waiting for assessment by a mental health practitioner or waiting for a mental health bed. A designated room

within the EDU was used to accommodate patients with acute mental health problems was noted to be ligature free. Staff had completed environmental risk assessments for the rest of the department to reduce the likelihood of a patient being able to attempt suicide by way of the use of a ligature point. The risk of suicide by way of a ligature point was reported on the department's risk register. A range of risk assessments and dynamic risk management strategies were used to manage the risk which was rated as moderate on the risk register.There was good compliance noted with the completion of mental health risk assessments during the audit period of April 2018 to January 2019. Compliance was observed to be at or above 98% each month, with 100% compliance achieved in September, November and December 2018.

- Point of care testing was available within the emergency department enabling staff to reach clinical decisions without delay. For example, flu testing equipment was frequently used in the ED resulting in confirmed cases of flu being diagnosed within 30 minutes. This enabled staff to better manage patients and to isolate them where this was clinically indicated.

- The children's emergency department was co-located but physically separate, providing a secure area, which was not overlooked by adult patients and visitors. Concerns had been raised at governance and quality meetings regarding children being cared for in the adults' department after the children's department closed at night. Consequently, the minors area was identified as the most appropriate place to manage children out of hours, except for those patients who required enhanced levels of care; in those instances, children were moved to the dedicated children's resuscitation bay, or their care expedited to the children's inpatient service.

- Resuscitation equipment was not always checked in line with trust policy. Full weekly checks had been completed on 9, 25 and 30 January, 13, 15 and 20 February for one trolley located in major's B; the trolley had not had daily checks completed on 6, 7, 8, 10, 19, 24 or 26 February 2019.

- Hand hygiene practices and compliance remained poor with very limited hand decontamination taking place during the inspection.

Assessing and responding to patient risk

- Patients who self-presented to the emergency department were seen on arrival by a registered nurse, known as the navigator. Their role was to quickly assess patients (before they were booked in by receptionists) in order to direct them to the most appropriate area of the emergency department. This may be the minor or major treatment areas or the GP-led urgent care area when a GP was present to provide this service.

- The waiting room had been 'divided' by the use of red and blue floor covering to separate those patients who were waiting to be assessed, and those who had been assessed and were waiting for treatment. There was signage to direct patients on arrival to sit in the area designated 'red', where they would wait to be seen by the navigator. During our observation of this process we saw the signs were not sufficiently prominent. Patients and visitors were unsure what to do or where to sit when they entered the department and many went directly to the reception desk, where they were re-directed, or they asked other people in the waiting room.This was a common occurrence and was something we had previously reported on following our inspection of the emergency department in 2018. We observed the result of such a confusing and poorly signposted reception area was that patients were often not seen in time order and some patients in the blue area, missing the streaming process altogether, resulting in further delays to the commencement of their initial clinical assessment.

- The navigator's base was a glass-screened room, which enabled the nurse to observe the waiting room. This allowed them to quickly assess whether a patient required urgent attention. However, the positioning of the 'red' seating, just inside the entrance, meant that patients could not be easily observed by either the navigator or the reception staff. We were told that when more than four patients were waiting to be assessed, or if the initial assessment wait was longer than ten minutes, an additional nurse would be moved from the major treatment area to support the process. There was variation as to when this escalation protocol was applied, based on the clinical experience of the navigator. For example, we observed the waiting room at approximately 5.30 pm at which time six patients were seated in the red area waiting to see the navigator. At no time did the navigator escalate the queue which therefore meant patients were required to wait their

turn, and longer than 15 minutes before being assessed by the navigator. We observed the navigation process for a period of one hour during which three patients waited longer than fifteen minutes, with two patients waiting 20 minutes before being called through. The navigator was noted to be away from the navigation cubicle for a period of seven minutes during our observation. We asked the trust to provide us with data reflecting the time patients waited from arrival to initial assessment however they were unable to do so because of the nature of the patient pathway. Because patients were required to wait to see the navigator before they were booked in, there was no robust oversight of the time to initial assessment standard.

- Navigator nurses undertook comprehensive assessments of patients including a quick sequential organ failure assessment (qSOFA) and physical observations if these were clinically indicated. Navigator nurses were empowered to sign post patients to more appropriate clinical settings such as primary care or minor injury units if their presenting condition could be effectively managed outside of the emergency care pathway. We observed patients being appropriately signposted during the inspection. Patients identified by the navigator as requiring assessment and treatment in the major treatment area were directed/escorted there immediately or, if the pit stop was full, asked to sit in one of four numbered chairs at the back of the waiting room, where they could be easily observed by staff.

- We had previously reported the streaming process had not been working efficiently or effectively, especially when the department was busy. The trust provided draft standard operating procedures following our previous inspection in 2018; these had since been ratified at the time of this recent inspection. However, governance oversight of the waiting room remained limited. There was evidence of an awareness of the challenges faced by the department during times of surge activity. For example, there was a recognition of patients experiencing long waits in the reception area, as referenced in clinical governance minutes. Whilst high risk patients were relocated to the minor's area if clinical assessments were required and there was no capacity in the pit-stop or majors area, there appeared little other monitoring of the waiting room once patients had seen the navigator. This meant patients at risk of deterioration may not be identified in a timely way.

Ambulance handovers greater than 60 minutes

- We had previously reported frequent delays in the handover of patients by ambulance staff to emergency department staff. The emergency department was working with the ambulance service to improve the handover process. This remained the case during this recent inspection.

- The proportion of ambulance handovers delayed more than 60 minutes has been worse than England since the end of January 2019. From 28 January to 10 February, 12.8% of patients conveyed by ambulance had handover delays over 60 minutes, compared to England overall which had 2.9%. 17.4% of ambulance handovers were delayed by more than 60 mins between 4 to 17 Feb 2019. The proportion was statistically worse than the England rate, which was 2.8% in this period.

- A review of the February 2019 integrated performance report suggested there had been some improvements in the number of patients held on ambulances for periods longer than 60 minutes between April and July 2018. However, performance then deteriorated with a peak of patient holds noted from August 2018 through to December 2018. In December 2018 more than 600 patients were held for more than 60 minutes over the month.

- Staff told us that recent changes to general practitioner referral patterns had resulted in increased hospital bed occupancy which was impacting on the ability to move patients through the emergency department. This was reflected in the integrated performance report for February 2019 which showed an increasing trend in bed occupancy from December 2018 on-wards. As a result of poor departmental flow, staff reported patients were often held on ambulances outside the emergency department because of a lack of capacity to receive the patient in to the department. This occurred during the inspection when, shortly after our arrival, six patients were being held on ambulances outside the emergency department. At the 1 pm bed meeting four ambulances were holding their patients, and the ED corridor was full with patients who were waiting for clinical space to be created. There had been 107 reported four hour breaches (national standards require 95% of patients who attend an emergency department to be admitted, transferred or discharged within four hours from arrival) and one patient had been in the department for fourteen hours because of a lack of inpatient beds. At

approximately 4.20 pm, three patients remained on ambulances with one patient having been held for over one hour whilst a second patient had been held for 56 minutes.

- When patients were held on ambulances, a hospital and ambulance liaison officer (HALO) and a nurse from the ED worked collaboratively. Patients were seen to be assessed by a dedicated ED nurse as soon as the ambulance arrived in to the ambulance bay. Once a cubicle became available, patients were offloaded, with the sickest patients given priority. The nurse allocated to the ambulance bay continued to monitor patients; where a patient's condition worsened, the ambulance bay nurse liaised with medical colleagues to review the patient and to expedite the care of the patient as clinically indicated. This ensured the sickest patients were prioritised and treated without delays to their care or treatment.

- We were told that when more than six patients were held on ambulances, senior staff would activate an internal critical incident which led to patients being "cohorted" in the corridor adjacent to the nursing station located at the ambulance entrance. We observed this occur during the inspection. We noted the process resulted in a congested corridor. Patient privacy and dignity was compromised; there was little in the way of clinical leadership and confusion among nursing staff as to which patient posed the greatest clinical risk. On one occasion, we observed a patient's care being transferred between five different nurses.

- Nationally reported data suggested that in December 2018 the median time to initial assessment for patients conveyed by ambulance was 220 minutes compared to the England average of 9 minutes. The trust's median time was much longer than England for most of 2018. The trust's time ranged from 183 to 312 minutes compared to the England range of 7 to 9 minutes. However, further queries with the trust confirmed the data reported nationally was incorrect and that this was being resolved between the trust and their information technology service provider. The trust reported consistently good performance against the time to initial assessment standard. Between January 2018 and January 2019 the monthly median times to initial assessment for patients conveyed via ambulance ranged between 3 and 7 minutes which was better than than England range reported above.

- There were systems in place for the ongoing monitoring of risks to patients in the emergency department so that staff could identify seriously ill and deteriorating patients. The emergency department used a nationally recognised 'track and trigger' system to identify critical illness or deteriorating patients. For patients arriving by ambulance, the receiving nurse was required to record patients' observations, as recorded by the ambulance crew, and undertake a first set of emergency department observations; these observations were inputted in to the computer system which automatically generated a score. These scores were linked to escalation protocols which were observed to be used during the inspection. Staff could view the most recent early warning score clearly for each patient on the front screen of the patient administration system.

- Staff completed computer based risk assessments for the majority of patients who presented to the emergency department. The emergency department safety checklist prompted staff to complete a range of assessments and acted as a safeguard for ensuring specific tasks were completed for patients. For example, where patients had had an electrocardiogram (ECG), the checklist prompted nursing staff to confirm the ECG had been reviewed by a doctor or other senior clinical decision maker. Additionally, the safety checklist prompted staff to consider the holistic needs of patients, including whether the patient had a learning disability, was living with dementia, or if the patient was suffering from an illness which required them to take time sensitive medicines, for example, those with insulin-dependent diabetes or Parkinson's disease. Audit data provided by the trust suggested some variability in the completion of the safety checklist with compliance being reported as:

1. 95% - November 2018
2. 97% - December 2018
3. 81% - January 2019

- During the inspection we reviewed ten sets of medical records. Observations were completed frequently and risk assessments were completed. However, in one case, we noted that a frail elderly patient remained on a trolley for more than six hours despite being at risk of skin damage.

- The emergency department participated in a commissioning for quality and innovation (CQUIN) programme related to the management of patients with

possible sepsis. Between August and December 2018, 100% of patients with possible sepsis were screened upon arrival to the ED or other "direct admission" areas. The CQUIN required that at least 50% of those patients received antibiotics within 60 minutes from time of diagnosis; this target was achieved and exceeded during each month of the audit period. However, commentary in the February 2019 integrated performance report alluded to an overall deterioration in performance for the administration of antibiotics within an hour for the emergency department during the previous financial quarter.

Nurse staffing

- The emergency department was funded for an establishment of 163 full time equivalent registered nursing posts. At the time of the inspection, the vacancy rate was reported as 6.5%. This compared positively against the wider trust vacancy rate for registered nurses of 12.3%.
- The department used a range of band three care support workers and band four Associate Nurse Practitioners (Nursing) who worked alongside registered nurses. At the time of the inspection, the department was funded for 38 full time equivalent support workers. 41.3 were in post, producing an over-established position of -8.6%.
- There were processes in place for ensuring the department was staffed safely and Matrons met with care group managers and divisional nursing directors to review rosters and to predict any requirements for temporary staffing. Staff told us that regular bank and agency staff were used, so they were familiar with the department. There was a local induction checklist which was completed by temporary staff and records were held in the department. Between 30 December 2018 and 17 February 2019 a total of 24.8% of registered nursing shifts which were placed out for temporary staffing remained unfilled. During the same period, 22.7% of non-registered nursing shifts remained unfilled. Where shifts remained unfilled, we observed staff being moved from other departments such as the acute medical unit to help support the emergency department during periods of surge. Daily staffing huddles were held to consider the activity of the department in real-time and to identify any additional staffing requirements based on patient demand and department capacity

- A total of 22 nurses and six support workers were deployed across the emergency department 24 hours a day. Three nurses were deployed to manage the resuscitation area which was in line with national recommendations. The resuscitation area was further supported by a senior clinician 24 hours a day. We reviewed a range of rota's which showed some variation in the filling of shifts which was consistent with the data provided by the trust. We noted the layout of the department meant additional staff were required to ensure there were sufficient numbers of staff available to meet patient needs.
- The department was staffed with a nurse-in-charge who did not take a patient case load. However, during the inspection we observed the nurse in charge undertaking duties which distracted them from leading the department, including the movement of trolleys, beds and equipment.
- The pit-stop area received patients who were conveyed by ambulance and also those patients who self-presented to the trust and who had been assessed by the streaming nurse as requiring rapid assessment and treatment. The area was staffed with three registered nurses and one support worker. We noted the support worker was co-ordinating flow within the area whilst nursing staff provided care and treatment to patients. This meant that at times, there were delays in communication between the nurse in charge and the Pit-stop as the support worker was required to liaise with nursing staff to determine which patients were most appropriate for being transferred out of the pit-stop area. A band four Associate Practitioner (Nursing) was observed to co-ordinate flow through Majors B.
- The trust reported the following levels of basic life support training:

1. Unregistered Band 2 - 65%
2. Nursing (registered, Band 5 or above) -75%

- 100% of relevant staff had completed paediatric advanced life support training.

Medical staffing

- The trust reported a funded substantive consultant workforce of 16.6 full time equivalent establishment. At the time of the inspection, there were 18.8 full time equivalent consultants in post.

Urgent and emergency services

- There was senior medical presence in the emergency department for 24 hours a day, seven days a week. Consultants were present for 16 hours a day, which is in line with the Royal College of Emergency Medicine's recommendations. There were 2.5 whole time equivalent (FTE) consultants in children's emergency medicine, in addition to five dual-trained (adults and children) consultants and a specialist trainee.
- We saw consultants working clinically in the department. They led the treatment of the sickest patients, advised more junior doctors and ensured a structured clinical handover of patient's treatment when shifts changed. We observed early senior involvement in the treatment of patients throughout our inspection.
- There were gaps reported in the junior doctor workforce. The trust reported a vacancy rate of 31.2% against the budgeted junior doctor establishment. To mitigate against any staff shortages, locum doctors were sourced to back-fill rota gaps. Board rounds occurred daily during which medical and nurse staffing challenges were both discussed and actions identified.
- Junior doctors spoke positively about working in the emergency department. They told us that the consultants were supportive and always accessible.
- 98% of medical staff had completed basic life support training. 98% of relevant medical staff had completed advanced trauma life support or other equivalent course.

Are urgent and emergency services caring?

Not sufficient evidence to rate ●

Compassionate care

- During clinical consultations, staff were observed speaking to patients with compassion and respect. Staff took time to locate appropriate clinical areas to consult with and assess patients, compared to undertaking care in corridors as had been previously observed.

However,

- There were occasions when the privacy and dignity of patients was not protected. During feedback we provided examples of occasions when nursing staff had failed to cover patients up; instead opting to half close cubicle curtains. Frail elderly patients were left for periods of time in Majors with no access to call bells, and left in unacceptable states of undress. Patients were observed being moved through the department without being spoken too; staff routinely released the brakes on trolleys and started moving patients without communicating with the patient. Again, this was a common observation; it showed little in the way of positive communication between patients and staff.
- There was little consideration given to the individual needs of those patients who were cohorted in corridors. For example, one patient with learning disabilities became increasingly distressed due to being overly stimulated whilst they were held in the corridor for an extended period of time. A second, frail and confused elderly patient who was offloaded from the ambulance subsequently started to wander; the patient was initially offered a chair but an increase in wandering meant a number of staff were required to support the patient so they did not fall due to being unsteady on their feet. Staff subsequently located a trolley for the patient however they remained in the corridor for an extended period of time.

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

Not sufficient evidence to rate ●

As this was a focused inspection we have not inspected the whole of this key question and the rating has not been updated.

Access and flow

- Although the trust reported their operational status using nationally defined characteristics, some local leaders demonstrated a limited awareness of the system used. Operational Pressures Escalation Level (OPEL) provides a nationally consistent set of escalation levels, triggers and protocols for local A&E Delivery Boards and ensures an awareness of activity across local healthcare providers. Escalation levels run from OPEL 1; the local health and social care system capacity is such that organisations can maintain patient flow and are able to meet anticipated demand within available resources to, OPEL 4; Pressure in the local health and social care system continues to escalate leaving

Urgent and emergency services

organisations unable to deliver comprehensive care. The nurse-in-charge and local operations manager both reported they did not know what OPEL status they were operating at, in part because they had not yet attended the operational bed meeting. The Chief Operating Officer later reported the trust was at operational pressures escalation level 3. This meant the local health and social care system was experiencing major pressures which compromised patient flow with activity likely to increase further. A range of admission avoidance schemes and direct admission protocols had been developed to help alleviate pressure on the emergency department. A frailty intervention team was present seven days a week and had access to a new frailty unit. This enabled the team to assess, support and discharge frail patients more quickly from the emergency department.

- A range of acute medical pathways had been established to help improve patient flow across the emergency department. A consultant-led telephone advice line had been established approximately five years ago. The trust reported that less than half of all calls received by the help-line resulted in a patient being referred to the ED or other clinical in-patient setting. Without the help-line, staff reported those cases discussed with consultants would have historically resulted in patients being sent to the acute care setting for on-going care and treatment. Staff spoke positively about the help-line as it helped keep small but consistent numbers of patients from being admitted to hospital.

- A re-launch of the clinically-led admissions policy was in the process of being implemented at the time of the inspection which would allow ED staff to directly admit patients to appropriate in-patient beds, thus helping improve flow across the emergency care pathway.

- In December 2018, the trust's monthly median total time in A&E for all patients was 164 minutes compared to the England average of 158 minutes. The trust median total time in A&E has been similar to the England overall since January 2018.

- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of

arrival in the emergency department. From January 2018 to December 2018 the trust failed to meet the standard and performed worse than the England average.

- In December 2018, 71.4% of patients spent less than four hours in the Major Type 1 departments at the trust. This was much worse than England's target 95% and worse than the England overall of 79.3%.

- 22% of patients waited between 4-12 hours from the decision to admit to being admitted. This was similar to England overall but better than December 2017 which was 47% at the trust.

- 0 patients waited more than 12 hours between June and December 2018 going into the winter period.

- The recommended time patients should wait from time of arrival to receiving treatment should be no more than one hour. In Dec-18 the median time to treatment was 51 minutes, which is shorter than the recommended time and the England average of 60 minutes. The trust median time was generally shorter than the England overall time for all of 2018.

- Senior members of the trust leadership team reported an unprecedented increase in the level of activity experienced by the emergency department in the two week period prior to our inspection. Information from the February 2019 integrated performance report made reference to an increase in the number of ambulances conveyed to the trust during January 2019 (4,084 versus 3,501 for the same period in 2018 - an increase of 16.6%). Overall ED attendances were reported to have increased by 8.6% when compared to January 2018. The increase in patient activity, as well as the number of patients referred in to the organisation from general practitioners and other community and primary health care professionals was reported to have increased the number of patients directly admitted to the hospital. This had led to increased bed occupancy rates, therefore impacting on the flow across the emergency care pathway.

- We had previously reported the layout of the department had been reconfigured over time to create more capacity but the size of the department and physical separation of the two major treatment areas did not readily allow for good communication. Senior staff had radio contact with each other but communication remained challenging. This remained

the case at this inspection. Whilst each area had an assigned health professional who was "In charge" of that clinical area, there was disjointed and often poor communication between the nurse-in-charge of the entire department; the lead consultant; and those in charge of the sub-sections of the department. This impacted on the ability of the team to manage departmental flow.

- Cubicle spaces were often occupied with patients who were waiting care and treatment. For example, one patient waited over five hours before they received the appropriate level of care and subsequently discharged. Another patient was delayed for discharge because there was no bladder scanner available; we observed the scanner being moved around the department. This was another example of how the footprint impacted on the ability of staff to deliver effective and timely care. Flow through majors B was poor, with patients often waiting for diagnostic results to become available before treatment decisions could be made. This was despite there being sufficient capacity in the emergency decision unit to accommodate such patients. The lack of senior clinical decision making was likely to be impacting on the ability of the wider medical and nursing teams to recognise early those patients who could be transferred to more appropriate clinical settings within the emergency pathway as compared to waiting in a majors cubicle whilst patients were held in the corridor.

Are urgent and emergency services well-led?

Not sufficient evidence to rate ⬤

As this was a focused inspection we have not inspected the whole of this key question and therefore have not updated the rating.

Leadership

- At this inspection, staff were proud of the progress they had made however a small contingent of senior staff continued to remain hostile and uncooperative towards the inspection team. This sense of animosity and hostility suggested further work was required in regards to action 5.3 of the wider ED improvement plan. This action described the need for a stronger and more

united leadership team within the ED. Our observations on the day of the inspection was that the department continued to lack a sense of collaborative clinical and nursing leadership.

- We observed that once the ED clinical lead took control of the department at approximately 4 pm, flow was generated across the department; the ambulance corridor was decompressed and patients who had remained in the department for longer than was clinically indicated were assessed, treated and discharged.

- We were not assured that all clinicians in the department had the same leadership skill set and understanding as was demonstrated by the clinical lead; the development of the ED improvement plan correctly identified the need for further work in this regards. We noted all actions related to this specific point of the ED improvement plan had been completed. We have set out must do actions (Musts") within this report which suggests this area is reviewed to determine the effectiveness of the actions listed as complete.

Vision and strategy for this service

- We previously reported that the overall vision for the service was to develop an urgent care floor or 'one stop shop' for all unscheduled care. Plans had been developed which were captured in the Portsmouth Hospitals NHS Trust Emergency Floor Programme. This was a multi-agency approach to addressing the continued challenges faced by the local health economy of providing an effective emergency care programme. Investment had been secured which meant further plans could now be developed to implement a capital build at Queen Alexandra Hospital. Most staff we spoke with seemed to be appraised of this vision and early plans had been discussed at governance and quality meetings. A programme team and appropriate governance arrangements were in the process of being established at the time of the inspection, with the intention of delivering the new strategy.

- Daily board rounds were attended by colleagues from across the emergency department and acute medical unit. Current ED activity, staffing challenges and bed requirements were all discussed. Acute medicine board rounds were also undertaken daily during which ED capacity was further discussed and actions developed to help reduce pressures on the emergency department

where possible. We asked the trust to provide us with data to show how they were monitoring compliance with the trust's professional standards. Due to IT challenges, the trust was not able to report response times from speciality, once referrals had been made. The trust was working to resolve this during 2019.

Governance, risk management and quality measurement

- The service maintained a risk register which recorded known risks and rated them according to their potential impact. The risk register reflected the risks spoken about by staff in the department. The risk register further acknowledged the challenges inspectors identified during the inspection. There was a sense the leadership team were more aware of the challenges they faced than was the case in the previous inspection. Risks across the emergency care pathway had been considered and mitigating actions put in place for known issues. However, there remained risks for which mitigations were poorly thought through and implemented. This included the lack of robust clinical oversight and co-ordination of the waiting room and respective streaming processes. There was some "yo-yo" compliance against the completion of the ED safety checklist which raised concerns over the ability of the department to deliver sustainable change. Gaps in the checks of equipment had gone unnoticed suggesting some weaknesses in existing assurance mechanisms. The concept of monitoring best practice against privacy and dignity was poorly considered.
- Governance meetings occurred monthly. Consideration was given to standing agenda items including

complaints, incidents, local audit outcomes, local risks, operational concerns, safeguarding concerns, clinical effectiveness and the ED quality improvement plan. Attendance at the meetings was consistent with representation from nursing, medical and governance professionals. Outcomes of meetings were displayed across the department. Incidents were reviewed and lessons learnt were also displayed in all clinical areas, therefore raising the awareness of any changes to practice.

Culture

- A range of staff including doctors, nurses, support workers, administrative staff and representatives from the local NHS ambulance trust reported they were able to raise concerns to local the management team without fear of retribution. Staff told us they felt supported and were encouraged to be open and transparent. There was an appetite among staff to improve the quality of care provided in the department.
- Health professionals reported good multi-disciplinary working with positive relationships existing between doctors and nurses for example. We had previously reported teamwork, peer support and camaraderie as being the reasons why many staff enjoyed coming to work. Many staff described their work colleagues as their second family and told us they would not want to work anywhere else. This continued to be the case at this inspection despite the department having experienced very busy periods over the preceding weeks.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

Ensure patients receive a timely assessment of their care needs and that a plan of care is established and delivered in line with national best practice.

Ensure patients receive care and treatment in an environment which is fit for purpose and meets national standards.

Ensure staff consistently utilise safety measures as determined by trust policy.

Ensure the emergency department operates an effective and safe process for receiving and assessing patients who self-present to the department.

Ensure staff abide by the trusts values and behaviours at all times, including ensuring the privacy and dignity or patients is maintained.

Ensure medical equipment is checked and ready for use as defined by trust policies.

Action the hospital SHOULD take to improve

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 **Dignity and respect** 10.—(1)Service users must be treated with dignity and respect. (2)Without limiting paragraph (1), the things which a registered person is required to do to comply with paragraph (1) include in particular— (a)ensuring the privacy of the service user; (c)having due regard to any relevant protected characteristics (as defined in section 149(7) of the Equality Act 2010) of the service user. The privacy and dignity of patients held in the ambulance corridor was not always protected. Staff did not routinely speak to, or inform patients of their intention to transfer the patient to other parts of the emergency department. A patient was observed to be in a state of undress and without access to a call bell. Staff did not respond to meet this individuals needs.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Safe care and treatment** 12.—(1)Care and treatment must be provided in a safe way for service users. (2)Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include—

Requirement notices

(a)assessing the risks to the health and safety of service users of receiving the care or treatment;

(b)doing all that is reasonably practicable to mitigate any such risks;

(c)ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely;

(d)ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way;

(e)ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way;

(h)assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated;

Staff did not routinely decontaminate their hands before and after patient contact.

Resuscitation equipment was not routinely checked in accordance with trust policies.

Staff with the right skills and competence were not always deployed effectively across the department. This meant patients experienced delays in receiving the right level of care or treatment.

Risks associated with the management of patients in the waiting room and the ambulance corridor were not always considered or effectively mitigated against.