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	**Requires improvement**	
Medical care (including older people's care)	**Inadequate**	

Summary of findings

Letter from the Chief Inspector of Hospitals

Portsmouth Hospital NHS Trust is located in Cosham, Portsmouth. The main site provided by this trust is the Queen Alexandra Hospital, which is a 975 bedded District General Hospital providing a comprehensive range of acute and specialist services to a local population of approximately 610,000 people. The trust provides specialist renal services to a population of 2.2 million people across Wessex.

We carried out an unannounced inspection of the Queen Alexandra Hospital on 16, 17 and 28 February 2017, where we inspected the medical care services and the emergency department. We returned on 10 and 11 May 2017 and inspected the key question of 'well led' for Portsmouth Hospital NHS Trust. As part of this later inspection in May 2017 we visited the emergency department, four medical care wards and the Acute Medical Unit (AMU) to review ward to board governance arrangements. During our May 2017 inspection we identified concerns in both the emergency department and medical care wards and AMU, which have been reported on in this February 2017 report. To view our findings and report from the inspection of 'well led' for the Portsmouth Hospital NHS Trust please refer to our website.

We inspected and rated urgent and emergency care and medical care. Urgent and emergency care has been rated as requires improvement overall, and medical care has been rated as inadequate overall.

Our key findings were as follows:

Urgent and emergency care:

- The hospital was not performing well against the national four hour A&E standard, with 67-71% of all patients in the ED being seen within four hours.
- Twelve hour Decision to Admit (DTA) trolley breaches had risen rapidly with 226 recorded between January and March 2017.
- Not all incidents were reported within urgent and emergency care were graded correctly, or investigated thoroughly. Which meant opportunities to learn from incidents were missed.
- The service did not consistently adhere to duty of candour legislation and ensure patients and their families were given open communication when incidents occurred.
- Risk assessments had not been completed or updated for patients who had been in the department for more than 12 hours.
- Patients with mental health conditions were only assessed for their risk of deliberate self-harm which meant other risks may not be identified.
- Staff knowledge of mental health conditions and the Mental Health Act (MHA) 1983, was not sufficient to be able to safely care for patients in mental health crises.
- Staff did not observe patients with a mental health problem often enough, meaning patients had the opportunity to leave the department without challenge.
- There were insufficient staff numbers in the Emergency Decision Unit (EDU) to care for patients who attended the department with a mental health problem. Staffing was not always adjusted according to acuity and demand at any given time.
- Young people (as young as 15 years old) were admitted to the EDU with patients with mental health conditions without additional safeguards being applied.

Summary of findings

- We were not assured that the processes for safeguarding children were effective, or that the bruising protocol for actual or suspected bruising was being followed.
- There were missed opportunities to improve the service. Whilst some improvements with regards to the effectiveness of the area had been noted there were many risks within the department which had not been addressed, or had worsened. The governance system was not addressing these concerns in the emergency department.
- There had been some improvement initiatives in the ED such as the navigator nurse and pitstop and some good areas of practice noted.However, ED performance was showing a downward trend for some areas of performance.
- Staff did not always complete daily checks on emergency equipment within the ED.
- Some specialty consultants were resistive to the medical take model which meant there were delays in patients receiving specialist assessment and/or treatment in the ED.

Medical Care:

- Overall, the quality of care on the medical wards in relation to emergency medical care was very poor.
- Not all incidents were categorised correctly. The quality of investigations was poor, and lessons to be learned or care and service deliver problems were not always identified.
- The trust did not consistently adhere to duty of candour legislation and ensure patients and their families were given open and honest communication when incidents occurred.
- Medicines management policies were not always followed in the acute medical unit and medical wards to protect the safety and wellbeing of patients.
- Patient confidential information was not stored securely and documentation was not always accurate or updated in a timely manner.
- Staff did not always consistently follow infection control procedures on medical wards.
- Consent to treatment was not always obtained in line with the Mental Capacity Act (2005).
- Staff administered medicines covertly and we did not find evidence that appropriate plans of care were in place for patients who required chemical and physical restraint.
- The inspection team had significant concerns about the safety and care of vulnerable people such as frail older persons or patients living with dementia.
- Staff caring for patients living with dementia did not always carry out a dementia assessment or use the dementia pathway.
- Staff did not always recognise or act appropriately in response to serious safeguarding concerns. Staff did not have sufficient knowledge of essential legislation and procedures in order to safeguard patients.
- Staff we spoke with did not have knowledge of the trust's pain assessment tool for patients who could not verbalise their pain.
- There were gaps in the care documentation for the most vulnerable patients who were at high risk of pressure sores.
- Patients, some of which were deemed at risk of malnutrition were not assisted with their meals.
- The trust did not always declare mixed sex breaches as they occurred in line with current guidelines.

Summary of findings

- There were significant concerns regarding the flow of patients throughout the urgent medical pathway. The acute medical unit (AMU) had bed occupancy significantly higher than the England average and escalation areas were consistently in use. This affected waits for cardiac and renal day case procedures. .
- Patients were moved both during the day and night for non-clinical reasons to aid bed availability.
- Some staff were frustrated and demoralised. Levels of staff sickness and staff turnover on AMU were above the England average and showing an upward trend.
- Staff did not feel listened to or connected to senior management. Allegations of bullying and harassment had been made directly to CQC and not all staff were aware of the process to raise concerns within the trust.
- Department risk registers did not always reflect the current risks or demonstrate risks were effectively reviewed or managed.
- Although some strategies were in place to improve the acute medical pathway, there was no evidence to show these had been embedded or had a significant impact on patients' care. . We could not evidence any significant or sustained improvements in medical care since our previous inspections.
- There were shortages of junior medical staff and consultants on AMU. Nursing shifts were not always filled which meant unwell or vulnerable patients did not receive the appropriate level of care and supervision. Staffing was not always adjusted according to acuity and demand at any given time.

We found the following areas of good practice:

- Patients and their relatives told us they generally felt they were well cared for while in the ED.
- Patients were given hot food and drinks if their transfer from the ED was delayed.
- Patients arriving at the ED were seen and assessed quickly by a senior doctor or nurse.
- Staff in the ED followed infection control procedures to reduce the risks cross-contamination.
- ED staff felt more connected with senior managers than on previous inspections and were engaged with initiatives to drive improvements.
- Staff in the ED treated patients and their relatives with dignity, respect and compassion.
- TARN data showed better than national average outcomes for patients with severe or life threatening injuries.

- Between November 2016 and March 2017 93% of patients said they would recommend the A&E service to family and friends, higher than the national average of 87%
  - The introduction of pitstop provided a rapid assessment and treatment to patients who attend the Emergency Department.
  - The trust had an identified pathway for patients living with dementia that included assessment, liaising with the older persons' mental health team and discharge planning

For the areas of poor practice the trust needs to make the following improvements.

Importantly, the trust must:

- Staff working with patients must have sufficient knowledge and skills to care for patients presenting with mental health condition.
- Staff within the emergency and medical areas must have sufficient knowledge of the Mental Health Act (MHA), 1983, so they understand their responsibilities under the Act.

Summary of findings

- Ensure that all clinical staff have knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards, and implement them effectively.
- Systems must be in place to ensure that the risks of detained patients, including the risk of absconding, are fully assessed and mitigated where possible.
- Review the processes for the safeguarding of vulnerable adults and children to ensure that safeguarding processes work effectively across all services.
- Safeguards must be put in place when children or young people are admitted into adult environments such as the EDU to ensure they are sufficiently safeguarded from avoidable harm.
- Ensure the Local Safeguarding Children Board protocol for the management of actual or suspected bruising must be followed in all situations where an actual or suspected bruise is noted in an infant that is not independently mobile.
- Staff mandatory training should be above the hospital's own target of 85%.
- Patients should not be transferred from ambulance trolleys in the corridor outside pit stop.Staff should move the patient to a more discreet area before attempting transfer, unless urgent transfer is required due to the patient's clinical condition.
- Patients waiting in the corridor for a space to become available in the 'pit stop.' area should be either observed by staff at all times or have means of summonsing immediate help if required.
- Staffing numbers and skill mix of staff working in all areas must reflect patient numbers and acuity which should be adjusted according to variations in need.
- Staff in the medical services must follow the trust's medicines management policy to ensure that medicines and prescribed, stored and administered appropriately.
- Patients in the ED must be seen by a senior medical doctor in a timely way following referral to medical services.
- The acute medical model must be immediately reviewed to ensure that patients are seen by a treating physician and treated at the earliest opportunity.
- Equipment must be checked as per individual ward protocols to ensure it is safe and ready for use.
- Risk assessments must be completed to assess the range of risks to patients being cared for in escalation areas. These must take account of environmental factors such restricted access to curtains, call bells and oxygen. These risks must be mitigated where possible.
- Improve quality of incident grading and classification to ensure that they are escalated and investigated appropriately.
- Improve the undertaking of duty of candour and being open following incidents.
- Improve flow through the hospital to prevent patients being cared for in the ED for longer than necessary.
- Patients must not wait on trolleys for more than 12 hour periods in line with national standards.
- The hospital must declare mixed sex breaches as they occur in line with Department of Health guidance.
- Improve processes to enable staff to safely speak up about concerns. All staff must know how to raise issues regarding bullying and harassment.
- Protect patient's confidentiality through safe storage of records.

Summary of findings

In addition the trust SHOULD ensure:

- Conversations between the navigator nurses should be held in a private area to preserve the patient's dignity and respect.

Following the inspections of the Queen Alexandra Hospital in February and May 2017 we took immediate action to ensure the safety of patients. We have taken this urgent action as we believe a person will or may be exposed to the risk of harm if we did not do so. Details of this action are included at the end of the report.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating		Why have we given this rating?
Urgent and emergency services	**Requires improvement**		The emergency department has been rated requires improvement overall. With effective and caring rated as good, responsive and well led rated as requires improvement and safety rated as inadequate. Incidents were not always thoroughly investigated which meant actions were not identified and lessons were not being learnt. Some daily checks on emergency equipment were not routinely carried out. Staff compliance with mandatory training requirements fell short of the hospitals target of 85%. Staff knowledge of mental health conditions and the Mental Health Act (MHA), 1983, was not sufficient to be able to safely care for patients in mental health crises and meet the needs of all patients in this area. There were insufficient staff numbers in the Emergency Decision Unit (EDU) to care for patients with a mental health condition. Staff did not observe patients with a mental health condition often enough, which meant that patients had the opportunity to leave the department without challenge. Patients were assessed only for their risk of deliberate self-harm. This meant patients were experiencing other psychiatric disorders may not have their risks accurately identified. Vulnerable young people were admitted into the EDU with adult patients, many of which were in mental health crises. We were not assured that the processes for safeguarding children were effective within the emergency department or that the bruising protocol for actual or suspected bruising was being followed. Patients waiting in the corridor were not always observed by staff and had no means of summoning urgent help if required. Flow through the department was often compromised by a lack of available hospital beds. The hospital was not performing well against the national four hour A&E standard, with 67-71% of all patients in the ED being seen within four hours. Twelve hour trolley decision

Summary of findings

to admit breaches had risen rapidly with 226 recorded between January and March 2017. There were delays for patients referred to acute medical services to be seen by a senior medical doctor. However,
Patients and their relatives told us they generally felt they were well cared for while in the department.
Patients arriving at the department were seen and assessed quickly by a senior doctor or nurse.
Staff were aware of infection control procedures.
Security staff were the only staff group who demonstrated excellent knowledge and understanding of the Mental Health Act, 1983 and the Mental Capacity Act, 2005.
TARN data showed better than national average outcomes for patients with severe or life threatening injuries.
There had been increased staff engagement via lunchtime drop-in sessions and multi-disciplinary staff engagement meetings.
The development of the new pitstop area had reduced the number of patients who had to wait in the corridor and helped to reduce the amount of time it took for patients to see a doctor.

Medical care (including older people's care)

Inadequate

Medical care has been rated Inadequate overall. With safe, caring, effective and well led rated as inadequate and responsive rated as requires improvement.
Overall the care provided within this service was very poor. Staff did not always recognise and act appropriately in response to serious safeguarding concerns. Consent to care and treatment was not always obtained in line with the Mental Capacity Act (2005). Staff administered medicines covertly and we did not find evidence that appropriate plans of care were in place for patients who required chemical and/ or physical restraint.
Staff did not robustly assess, monitor or manage risks to patients. Risk assessments had not been completed or updated for all the escalation areas and additional beds in use. Vulnerable patients such as frail older persons and patients living with dementia did not have their needs appropriately assessed and risks for those patients were not sufficiently mitigated.

Summary of findings

Medicines management policies were not always followed in the acute medical unit (AMU) and medical services. Patient confidential information was not stored securely. Staff did not always consistently follow infection control procedures. Staff did not always respond to patients when they asked for assistance. On some occasions, the inspection team had to request that staff intervene to maintain patients' safety. Patients, some of which were deemed at risk of malnutrition were not assisted with their meals.

The trust did not always declare mixed sex breaches in line with current guidelines. Not all incidents were reported, and some were categorised incorrectly. Care and service delivery failures were not always correctly identified during investigations of incidents. The trust did not consistently adhere to duty of candour legislation and ensure patients and their families were given open and honest communication when incidents occurred.

AMU had bed occupancy significantly higher than the England average and escalation areas were consistently in use. Patients were moved both during the day and night for non-clinical reasons to aid bed availability. Patients did not have timely access to discharge from hospital.

Staff were frustrated and demoralised. Levels of staff sickness and staff turnover on AMU were above the England average and showing an upward trend. Staff did not feel listened to or connected to senior management. Allegations of bullying and harassment had been made directly to CQC and not all staff were aware of the process to raise concerns within the trust.

Governance processes were not effective at identifying risks and improving the safety and quality of care and treatment. There was no clear or formal strategy to improve the urgent medical pathway and we could not evidence any significant improvements since our inspection in September 2016. The urgent medical pathway was still medically led and not all consultants were supporting necessary changes in the urgent medical pathway.

Not all staff had completed their mandatory training and the compliance for some staff groups was significantly lower than the hospital target. Not all

Summary of findings

staff completed safeguarding adults training to the appropriate level. Competency assessments for both permanent and agency nursing staff were not always in place.

However,

There was a standardised pain assessment tool was consistently in use which supported the management of pain in patients who could communicate verbally. Some patients and relatives praised the care they received on the renal day unit (RDU) and AMU.