East Lancashire Hospitals NHS Trust

Royal Blackburn Hospital

Inspection report

Haslingden Road
Blackburn
BB2 3HH
Tel: 01254263555
www.elht.nhs.uk

Date of inspection visit: 12 May to 13 May 2022
Date of publication: N/A (DRAFT)

Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at Royal Blackburn Hospital

Inspected but not rated

The Royal Blackburn Hospital is part of the East Lancashire Hospitals NHS Trust, which provides acute and community healthcare to people of East Lancashire and specialist care services for the people of Lancashire and South Cumbria.

The Trust employs 8,000 staff and treats over 700,000 patients a year from the most serious of emergencies to planned operations and procedures. The trust has 1079 beds across 48 wards, on five hospital

sites. We carried out this unannounced focused inspection of urgent and emergency care services provided by this trust because we received information giving us concerns about the safety and quality of the services. The findings from this inspection were also used as part of the Urgent and Emergency Care (UEC) inspection programme which is looking at the access and flow of patients throughout the northwest integrated care system (ICS).

There were multiple concerns raised regarding some key areas of the service. Concerns were raised regarding the care provided to patients in corridors of the department and what this meant for patient safety and the quality of their experience. Long waits, a lack of privacy and meeting patients basic care needs were included as examples of the impact this was having.

Further concerns were raised regarding the level of staffing for both nurses and doctors to provide adequate levels of care and to allow staff to take regular breaks. Nutrition and hydration were also cited as needs that many patients were not having met due to the pressures in the department.

Infection control measures were also reported as being affected as well as the supply of key equipment to provide care and treatment.

A summary of CQC findings on urgent and emergency care services in Lancashire and South Cumbria.

Urgent and emergency care services across England have been and continue to be under sustained pressure. In response, CQC is undertaking a series of coordinated inspections, monitoring calls and analysis of data to identify how services in a local area work together to ensure patients receive safe, effective and timely care. We have summarised our findings for Lancashire and South Cumbria below:

Lancashire and South Cumbria.

Provision of urgent and emergency care in Lancashire and South Cumbria was supported by services, stakeholders, commissioners and the local authority.
We spoke with staff in services across primary care, integrated urgent care, acute, mental health, ambulance services and adult social care. Staff felt tired and continued to work under sustained pressure across health and social care.
We found demand on urgent care services had increased. Whilst feedback on these services was mostly positive, we found patients were accessing these services instead of seeing their GP. Local stakeholders were aware that people were opting to attend urgent care services and were engaging with local communities to explore the reasons for this.

The NHS 111 service which covered the all of the North West area, including Lancashire and South Cumbria, were

Our findings

experiencing significant staffing challenges across the whole area. During the COVID-19 pandemic, the service had recruited people from the travel industry. As these staff members returned to their previous roles, turnover was high and recruitment was particularly challenging. Service leaders worked well with system partners to ensure the local Directory of Services was up to date and working effectively to signpost people to appropriate services.

However, due to a combination of high demand and staffing issues people experienced significant delays in accessing the 111 service. Following initial assessment, and if further information or clinical advice was required, people would receive a call back by a clinician at the NHS 111 service or from the clinical assessment service, delivered by out-of-hours providers. The NHS 111 service would benefit from a wide range of clinicians to be available such as dental, GP and pharmacists to negate the need for onward referral to other service providers.
People who called 999 for an ambulance experienced significant delays.

Ambulance crews also experienced long handover delays at most Emergency Departments. Crews also found it challenging managing different handover arrangements. Some emergency departments in Lancashire and South Cumbria struggled to manage ambulance handover delays effectively which significantly impacted on the ambulance service's ability to manage the risk in the community. The ambulance service proactively managed escalation processes which focused on a system wide response when services were under additional pressure.

We saw significant delays for people accessing care and treatment in emergency departments. Delays in triage and initial treatment put people at risk of harm. We visited mental health services delivered from the Emergency Department and found these to be well run and meeting people's needs. However, patients experienced delays in the Emergency Department as accessing mental health inpatient services remained a significant challenge. This often resulted in people being cared for in out of area placements.

We found discharge wasn't always planned from the point of admission which exacerbated in the poor patient flow seen across services. Discharge was also impacted on by capacity in social care services and the ability to meet people's needs in the community. We also found some patients were admitted from the Emergency Department because they couldn't get discharged back into their own home at night.

Increased communication is needed between leaders in both health and social care, particularly during times of escalation when Local Authorities were not always engaged in action plans.

Urgent and emergency services

Inspected but not rated

Our rating for this service had not changed. We have not rated the service as we did not inspect all the elements. During the inspection we found that;

- The service did not always have enough nursing staff to care for patients and keep them safe. The emergency department had experienced challenges to maintaining adequate levels of substantive nurse staffing, this risk was mostly mitigated with the use of both bank and agency staff.
- Over the past 12 months the pressures on the service and the wider health and social care system meant that not all patients had received treatment promptly within the emergency department, the service had not met a nationally set standard of 95% of patients to be either admitted, transferred or discharged within four hours of attending the emergency department. However, this was seen as a challenge nationally with no other emergency department in England being able to meet this standard.
- In response to the need to allow the region's ambulance service to handover patients in a timely manner and allow them to return and respond to the risk in the community, patients were being cared for in additional designated areas on the emergency department's corridors. This meant that staff had additional patients to monitor and care for, there was reduced privacy and dignity for patients and some patients even shared a corridor space when demand was extreme.
- There were long waits in the emergency department, sometimes over 12 hours. There had been instances where patients had been cared for in the emergency department overnight due to the lack of inpatient beds in the hospital and there was no space to accommodate beds for these patients.

However,

- The service controlled infection risk well. Areas we visited were visibly clean and staff wore the correct personal protective equipment in line with trust policy.
- Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided effective care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Most staff we spoke with felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Urgent and emergency services

Is the service safe?

Inspected but not rated

We have not rated safe as we did not inspect all the elements.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas of the emergency department were visibly clean and had suitable furnishings which were clean and well-maintained. However, cleaning records and schedules were not always up to date and did not demonstrate that areas had been cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE). There was a suitable supply of PPE such as gloves, masks and aprons throughout the department. We observed staff wearing the correct PPE and staff carried out the correct procedure for donning and doffing of PPE when caring for a patient who may have a communicable disease.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw 'I am clean' stickers on mattresses of the trolleys which had been cleaned between patients.

Sharps bins were clean and were not overflowing however not all sharps bins had the date from when they had first been used documented on them.

There were hand washing sinks which had soap dispensers throughout the department. In areas where staff washed their hands there were posters displayed which demonstrated the correct hand washing technique.

All staff were trained with hand hygiene and compliance was part of their corporate induction, the trust corporate induction must be completed before staff were allowed into any post within the organisation. The emergency department had a 100% compliance for hand hygiene training through corporate induction training

The trust carried out monthly hand washing audits which were reported on through the monthly matron assurance report. The emergency department had received 82% compliance of its hand hygiene audit in March 2022.

Staff in the emergency department adhered to the bare below the elbow policy and we observed staff carrying out the correct handwashing technique during our inspection. We observed staff using hand sanitiser before and after patient contact.

The emergency department had developed an area for the care of patients suspected of having COVID-19 which consisted of eight negative pressure rooms. Negative pressure rooms prevent cross contamination from room to room using ventilation to produce air pressure which allows the flow of air into a room but does not allow it to escape.

Urgent and emergency services

The department had four cubicles which could be used for the resuscitation of patients suspected of having COVID-19, this allowed staff to carry out procedures such as airway interventions which are known aerosol generating procedures (AGP) which in turn reduced the risk of cross contamination in the departments major resuscitation area. An AGP is a medical procedure that can result in the release of airborne particles from the respiratory tract when treating someone who is suspected or known to be infected by an airborne virus.

The emergency department waiting area had plastic screens between patient chairs to allow for social distancing and reduce the spread of airborne infections such as COVID-19. However, this had reduced the number of seating spaces there were for patients; senior nursing teams for the department informed us that there was a plan in place to remove these screens following government guidance which would return the waiting area to its original lay out.

The department carried out point of care (POC) testing for all patients who presented with COVID-19 symptoms in the department. POC testing involves performing a diagnostic test which produces a rapid and reliable result to identify infectious diseases such as COVID-19.

Environment and equipment

In times of normal demand and capacity in the emergency department, the design and maintenance of facilities, premises and equipment kept people safe. However, at the time of the inspection the use of the corridor spaces to accommodate the consistently, excessive pressure did not always keep patients safe.

The department consisted of a main waiting area, walk in patients entered their symptoms on an electronic tablet, for patients who presented with high risk symptoms such as chest pains or difficulty breathing they were directed to the reception desk where the triage process was started. They were then seen by a triage nurse in one of the department's assessment rooms.

There were seven ambulance triage beds in the emergency department, where patients were assessed. The department employed three hospital ambulance liaison officers whose role it was to review ambulances in transit to the hospital and coordinate care with the triage team, they worked seven days a week.

The emergency department had a 'fit to sit' area for patients who had been triaged and did not require access to a patient trolley. However, this area was small and unable to accommodate the number of patients who were deemed "fit to sit" who were then cared for on corridors.

Patients cared for in cubicles had access to call bells and staff responded quickly when called, however, patients cared in the corridors did not have access to call bells and had to find alternative ways to seek assistance, the department employed patient champions to assist patients being cared for on the corridor however due to staffing pressures these roles were sometimes not filled. We observed that most patients were reviewed regularly by staff, but the patients told us it was very difficult to get a staff members attention when it was busy.

We observed that there were 20 spaces identified on the corridors for patient care. These were clearly marked, and a nurse was allocated to each space. The spaces were used to house patients both in wheelchairs and on trolleys which did encroach on the corridor space, we also observed some patients being cared for on plastic chairs. Although this reduced the space for movement around the department the spaces did not hinder the fire doors.

Patients cared for in this department were moved into cubicles as soon as possible or in respect to their care needs. Personal care was performed in designated cubicles. Patients who were in the department for longer periods and were

assessed as at risk are nursed on a hospital bed where required such as elderly, frail, mental health patients. This was not routine as the width of the corridors did not easily support transfers and movement of hospital beds through the department. With regards to pressure area care, the mattress specification on the trolleys was the same as a hospital bed mattress, and the risk assessment, care plan and interventions remained the same.

The emergency department had two toilets in its majors area and three in the main waiting room , for patients who needed assistance to use the toilet this was carried out using commodes within two designated cubicles in the department. Staff we spoke with told us that this was sometimes a challenge when the department was experiencing increased demand. There were plans for building improvements which included an increase to the number of toilets within the emergency department.

The department had three assessment rooms which could be used to care for patients who had mental health conditions, these rooms were alarmed and ligature free. The rooms had two doors which could not be locked and could be opened from the outside, this allowed staff to intervene if a patient attempted to harm themselves. The mental health assessment area also had a toilet which was ligature free.

Staff carried out daily safety checks of specialist equipment. The department had eight adult emergency trolleys and one paediatric emergency trolley within the resuscitation area. It had three adult emergency trolleys within its majors area and one paediatric trolley within the paediatric emergency department. Each trolley had monthly, weekly and daily checks completed however, the storage of the checklist documentation was disorganised. This was raised with managers, who told us that they would review checklist documentation and improve its organisation.

The department had recently employed a procurement team who supported housekeeping staff to ensure adequate stock of medical equipment and supplies. Staff we spoke with did not report any issues with medical equipment or stock. We reviewed the departments medical stock room which had a suitable supply of equipment such as fluids and syringes, all the medical stock we checked was in date.

During the inspection, all medical equipment we checked had portable appliance testing. We checked seven electrocardiograms (ECG) which had all been serviced in the last 12 months and had the next date of service documented.

The service had limited facilities to meet the needs of patients' families. Due to Covid-19 precautions, visitors to the department were limited but the only facility we saw for visitors was a relative’s room. We saw that some patients on the corridors had relatives with them but due to the space limitations they could not have a chair.

The service had enough suitable equipment to help them to safely care for patients. Equipment such as hoists used to safely move patients had dates of the last and next service displayed on them.

The department had signage to direct staff and patients to fire exits, the department’s fire extinguishers had service checks completed within the last 12 months.

Staff disposed of clinical waste safely. Waste bins were available throughout the department. The department had a clean and dirty utility room, both rooms were visibly clean and well organised during the inspection.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

Urgent and emergency services

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. We reviewed four sets of patient notes of those patients cared for on the corridor. We found that all had observations of vital signs performed at triage and at regular intervals after that and they used a National Early Warning Score (NEWS 2) system. However, we noted that observations were delayed in some cases due to staffing pressures.

The emergency department carried out monthly NEWS 2 audits which were reviewed in the department's monthly governance meeting, for NEWS 2 audits carried out in March and April 2022 the department had scored 90% compliance for both months.

For patients who came to the department by ambulance, they were handed over by ambulance crews to the triage nurse team. The emergency department worked with the ambulance service to handover patients within the 15-minute national handover standard and rarely had patients waiting in ambulances outside the department.

Each patients information was entered onto an electronic ED board round system. The department had a clear standard operating procedure for undertaking board rounds with the Consultant and Nurse in Charge. These were undertaken every 2-3 hours depending on the number of patients within the department. This system displayed patients NEWS 2 scores and identified risks in line with key alert questions which were reviewed as part of the board round process. A department SAFE huddle was held twice daily where any patient risks were also identified and discussed.

The department carried out a monthly Nursing Assessment and Performance Framework (NAPF) which was designed to measure the safety and quality of patient care in clinical areas. These checks were carried out by the department's matrons and ward managers, the emergency department had achieved 88% compliance for April 2022. The department also carried out mini NAPFs, led by emergency department senior nurses and matron, following these assessments action plans were updated and shared accordingly. These were reviewed monthly by the assistant director of nursing and head of nursing.

During the week of the inspection the percentage of patients who arrived by ambulance at Royal Blackburn Hospital and were handed over within 15 minutes was 23%, 82% of patients were handed over within 30 minutes and 100% of patients had been handed over within an hour.

Staff knew about and dealt with any specific risk issues. Staff completed risk assessments for each patient on admission these included sepsis, falls and waterlow (for pressure area care). Staff knew how to recognise patients who were at risk of stroke or sepsis and knew the correct pathway to follow.

Staff in the ambulance triage department were pre alerted by ambulance crews with patients with potential sepsis illness. NEWS scores were completed on arrival into the department and we observed two patients who commenced sepsis treatment within 15 minutes of arrival. Primary surveys assessments were completed on all patients based on their clinical presentation. All ambulance patients were triaged in the department and not on the ambulances. We observed that the handover of patients from ambulance crews to triage staff was of good clinical quality.

Staff in the main triage area used the Manchester triage system for triaging patients on arrival. They worked well with reception staff to fast track any patients that the reception staff identified with concerns such as sepsis or chest pain. Neutropenic patients had a fast track pathway through triage to protect them from infections. There were adequate numbers of triage trained staff, 86% of the department's qualified nurses were triage trained.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff we spoke with told us that if they had concerns about a patient's mental health, they could ring the mental health team who would carry out an assessment. The department also had access to support from the mental health team through twice weekly phone calls with the management team.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The department had three specially designed rooms which could be used to safely care for and observe patients with mental health concerns.

Staff shared key information to keep patients safe when handing over their care to others. We observed three hourly Board Rounds where the nurse in charge and an emergency department consultant reviewed all patients and shared their plan of care.

Shift changes and handovers included all necessary key information to keep patients safe. Handovers during shift changes were carried out within each role for example the majors nurses handed over to majors nurses. Staff within the resuscitation areas handed over to resus staff with end of the bed handovers. The nurse in charge maintained a shift leader log which documented actions taken by the shift leader in response to the departmental challenges including escalation of patient numbers and staffing pressures.

Nurse staffing

The service did not have enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix but the department regularly managed with temporary staff due to vacancies and sickness. They gave bank and agency staff a basic induction.

Matrons calculated and reviewed the number and grade of nurses, and healthcare assistants needed for each shift in accordance with national guidance and had plans to make this more accurate. The matron for the department could adjust staffing levels daily according to the needs of patients, but they were not always able to fill the required shifts.

The rotas were completed by the Emergency Department rota coordinator and signed off each month by the matron. The rota was completed to ensure safe skill mix and was published with even numbers across all shifts, given the current vacancies. Once published the unfilled shifts were sent to bank and agency immediately and could be picked up six weeks prior to the shift date. However, we were told that local agencies paid higher rates when staff picked up shifts at the last minute and so the managers felt that they would often be waiting until very late before the shifts were filled. This meant that they were constantly worried about the staffing levels being safe.

If the shifts remained unfilled then this was discussed with the staffing matron at the start of the shift to identify potential moves from other wards to ensure safe staffing levels were maintained. The trust used the safer nursing care tool for inpatient wards, but this was not licenced for use within the Emergency Department. Health Education England had recently provided training for specific version of a safer nursing care tool to emergency departments, this assessment was to be undertaken twice yearly, over a period of 12 days each to look at the service capacity versus demand with regards to nursing staffing. This was due to take place in July 2022.

The service also employed Emergency Nurse Practitioners and Advanced Nurse Practitioners to support the nursing and medical workforce. We reviewed the rotas for May 2022 and saw that these posts spanned between 8am and 2am however there were gaps particularly in the shifts after 10pm.

There were planned numbers of staff for each shift with an expected level of 21 registered nurses on the early shift, 23 registered nurses on the late shift and 21 nurses on the night shift. They would be supported by 11 support workers on each shift. These levels had recently been increased by four registered nurses per shift to account for the unprecedented numbers of patients in the department. Recruitment was underway and there were nurses due to start but other posts had not yet been recruited to.

Our review of the rotas for 02 May 2022 to 22 May 2022 demonstrated that there were a variety of shift patterns to support certain times of day.

There was a twice daily (morning and afternoon) trust staffing huddle, which was led by a divisional director of nursing or deputy. Representatives from all divisions attended and all nurse staffing gaps were discussed and entered into a shared drive folder. We attended one of these meetings which was inclusive of all areas of the hospital to ensure that staff were utilised appropriately.

The emergency department utilised escalation shifts which were put out to bank and agency staff. These shifts were filled dependant on emergency department patient numbers. For example, if the department was above 55 patients, then an extra RN was requested per five additional patients.

If the department was unable to fill the current and/or escalation shifts, then an escalation allocation was used which ensured that patients were allocated as evenly as possible to each nurse.

The service was significantly reliant on the use of bank and agency staff. We saw from the rotas supplied, for May 2022, by the trust that there were high numbers of staff from the bank and agency utilised to staff the department. There were unfilled bank shifts most days. Staff from other areas within the hospital were regularly utilised to support the department and we saw this during our inspection. Those staff told us that they were happy to help but that the department was a very different place to work from their normal work areas which made it difficult for them to be as effective as they would like.

The trust also supplied information on staffing numbers and bank/agency fill rates for 11 April to 01 May 2022. It demonstrated that there had been significant staffing with bank and agency staff and when registered nurse shifts could not be filled more health care assistant roles were allocated. The weekend shifts appeared to be more difficult to fill, with some shifts only having 80% fill rates but health care support worker shifts were at 118% fill rates.

The service had high vacancy rates although they were recruiting to some of the posts.

At the time of the inspection there were 26.78 band five registered nurse vacancies in the emergency department which correlated to a recent increase in staffing establishment following a professional judgement review. There were 15 registered nurses waiting to start in post with various start dates.

During the month of the inspection, the emergency department had elevated sickness rates of 10.8% for registered nurses and 20.2% for healthcare support workers.

Newly qualified nurses had an induction period of between eight to ten weeks, this allowed for nurses to work supernumerary to achieve clinical competencies and become comfortable working within the emergency department. The department had introduced the national curriculum and competency framework for emergency nursing for all nurses within the department, for newly qualified nurses this set out developmental milestones for the first 12 months post qualification.

Urgent and emergency services

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. The medical staff matched the planned number. The department had 9.35 Whole Time Equivalent (WTE) equivalent consultants, 6.0 (WTE) locum consultants,20.8 WTE speciality doctors and 15.83 WTE junior doctors. The Royal College of Emergency Medicine (RCEM) recommends that a medium sized emergency should have between 18 and 25 consultant doctors. The emergency department was lower than this with 15.35 WTE consultants however it was over established for junior clinical fellows by 7 WTE clinicians.

We were told that medical staffing was at a good level for both consultant and middle grade doctors however there were challenges ensuring the levels of junior doctors. We reviewed shift rosters for medical staff through May 2022 and saw that there were minimal numbers of shifts uncovered. Consultants were available at all times.

We were told that the department had introduced a twilight shift to support the surge in attendances through that time which was having a positive impact. Our review of the shift rosters demonstrated this.

The service had a reliance on bank and locum staff. Managers could usually access locums when they needed additional medical staff. The service had a good skill mix of medical staff on each shift and reviewed this regularly.

From the shift rotas we reviewed for May 2022 we saw that there were multiple bank and locum shifts. We were told that there was additional challenge at weekends following a change to the junior doctor's work pattern from working one in two weekends to one in three weekends.

Managers made sure locums had a full induction to the service before they started work.

Managers told us that the majority of staff that filled bank and locum shifts were familiar with the department.

The service always had a consultant on duty including evenings and weekends.

The shift rosters for May 2022 that we reviewed demonstrated that there was always a consultant available.

We spoke with junior doctors who had recently started work in the department in the last six months, they told us that they had been well supported by senior clinicians and that their induction had been comprehensive. Junior doctors we spoke with told us that senior staff would ensure that they received adequate breaks and ensured that they did not work excessive overtime.

The department had recently developed an established route through its certificate of eligibility for specialist register (CESR) programme for speciality doctor to consultant role. This was seen as an important development as the department would reduce the number of staff leaving the department for training opportunities at other trusts.

Is the service effective?

Inspected but not rated

Urgent and emergency services

We have not rated effective as we did not inspect all the elements.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs however extended stays in the department resulted in patients only receiving cold meals and drinks.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. We saw patients being offered food and bottles of water however it was noted that for those patients being cared for in the corridors there were no facilities for them to have somewhere to place a cup or bottle of water. We saw staff supporting patients with drinks, but this was intermittent. We spoke to family members who had been offered food and bottles of water whilst they were waiting with their relative.

The department had recently started to bring two cases of bottled water into the emergency department waiting rooms following feedback from patients that the water jugs were not appropriate. We saw jugs of water and diluted juice available on the front desks for patients waiting to be seen.

Staff did not always fully and accurately complete patients' fluid and nutrition charts where needed. We saw fluid balance charts in two records which had been completed however we noted that it was recorded as a bottle of water given but not what had been drunk. Intravenous fluids were accurately recorded.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way in most cases we reviewed.

Staff assessed patients' pain using a recognised tool which we saw in the patient records.

Staff prescribed, administered and recorded pain relief accurately. We saw in patient notes that analgesia was administered and recorded correctly however, we noted delays in the prescribing of analgesia in some cases.

We spoke with four patients in the department who had received pain relief when it was needed. One patient we spoke with said that they informed staff that they were still in pain following the pain relief they had received, they were reviewed by a doctor following this who prescribed a different form of pain relief which the patient told us had helped.

Is the service caring?

Inspected but not rated

We have not rated caring as we did not inspect all the elements.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Urgent and emergency services

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. However, this was difficult at times when the emergency department was experiencing increased demand.

Due to the increased demand on the department and lack of flow through the hospital, the emergency department was overcrowded with patients being cared for on the department's corridor, this meant it was difficult to maintain patient's privacy and dignity.

We particularly observed care particularly for patients being cared for in the corridors, there were two cubicles which were utilised for care to maintain patient privacy.

Patients said staff treated them well and with kindness. We spoke to patients who said that the staff treated them with kindness and compassion. The patients were understanding of the pressures that the staff were facing.

We spoke with patients who told us that the staff were working very hard but they did not have enough time to clearly communicate the plan of care and so they were left wondering what was happening.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

We observed positive interactions between staff and patients in the department, for example one patient was distressed and shouting for help, staff responded quickly and talked the patient through what was happening next and why they were being moved to the resuscitation area for closer monitoring.

The department had staffing roles such as patient champions, which were specific clinical staff and were used to support patient interactions within the department. However, they were struggling to fulfil these roles on a regular basis. Patient champions were used to keep patients updated on their care, assist patients if they needed food and water and help patients to contact their family to give them updates. The department also had a dedicated member of staff who answered calls from family members to give updates on patient care.

The emergency department were actively recruiting care navigators who would support patients in the waiting room to use the electronic tablet triage system. They would also book appointments for patients to return at an appropriate time. The care navigators would also liaise with the triage team and keep patients updated on waits and ensure their needs were met while waiting.

Is the service responsive?

Inspected but not rated

We have not rated responsive as we did not inspect all the elements.

Urgent and emergency services

Access and flow

People could access the service when they needed it but did not always receive the right care promptly due to pressures on capacity caused by high volumes of patients accessing the service and shortages of available beds for transferring patients out of the department. Staff risk assessed patients who attended the emergency department and treated those with urgent needs promptly. However, reviews for patients in the emergency department from doctors in other specialties were not happening in accordance with agreed timescales.

Managers monitored waiting times; patients could access emergency services when needed however they did not always receive treatment within agreed timeframes and national targets. The number of patients attending the emergency department through May 2022 was above 400 per day on three occasions whilst in April 2022 it peaked at 380.

The number of patients attending classed as minors compared to all attendances was consistently 10% above the England average through May 2022, with a similar picture in April 2022 which could indicate that patients are attending the emergency department rather than accessing other healthcare services such as their GP or walk in centre.

The median time from arrival to initial assessment was about the same as the overall England median between January and August 2021 however since then performance had worsened and in April 2022 it was 24 minutes compared to an England average of 10 minutes.

The department used a streaming tool to allow it to monitor the number of patients coming to the department and the acuity of these patients so that the service could highlight gaps in care and better plan for this in the future. Results from the streaming tool had resulted in an increase in the departments staffing establishments for both the medical and nursing workforce.

Through the use of the department's streaming tool, the department was able to refer patients to an alternative care centre who did not need care at the emergency department. During our inspection seven patients were referred to an alternative trust department. In addition, information provided by the trust showed that during the inspection period 15 patients who had received care at the emergency department had a primary care outcome and could have been reviewed by a GP. This type of information could be used to help plan future service provision.

Patients who attended at triage with emergency dental problems would automatically be referred to the region’s emergency dentistry hospital and would receive a call from the dentistry hospital to organise an appointment. This was seen as an improvement for patients as medical doctors were not trained to treat dentistry emergencies and meant that patients did not have to wait in the department to be referred.

However, the percentage of patients streamed to primary care services remained consistently below the England average of around 17% in May 2022 at around only 3%.

Managers and staff worked to make sure patients did not stay longer than they needed to in the department, however they were not always able to achieve this. From February 2021 to January 2022 the trust’s monthly median total time in the emergency department for all patients was slightly higher than the England average. Despite multiple workstreams to try and reduce the length of time patients spent in the department, in the three months prior to our inspection, the average time patients spent in the department had been increasing. In February 2022 the average was 371 minutes (6.2 hours), increasing to 386 minutes (6.4 hours) in March 2022 and 398 minutes (6.6 hours) in April 2022.

Urgent and emergency services

The number of patients leaving the service before being seen for treatments was low. In March 2022 the percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was 2.0%, compared to the England average which was 4.6%.

Managers monitored patient transfers and followed national standards. The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard between March and December 2021.

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 February 2021 to January 2022 the trust failed to meet the standard and performed worse than the England average. In recent month reported on May 2022, performance at the trust was 57% against the England average of 60%. In January 2022, 1339 patients waited over four hours, this was a significant increase from February 2021 when 497 patients waited over four hours.

Over the 12 months from February 2021 to January 2022, 560 patients waited more than 12 hours from the decision to admit until being admitted. The number of patients waiting more than 12 hours had increased monthly since July 2021 and by April 2022, there were 771 patients waiting more than 12 hours to be admitted.

Current waiting times for triage and access to a clinician were clearly displayed in the emergency department on a digital display. This also included waiting times for other local urgent care centres operated by the trust. For those patients that had been triaged and deemed safe and appropriate to travel they were offered return transport to those locations to reduce the patient wait if the patient chose to do so.

Both the main emergency department and ambulance triage had access to the trusts fast track admission pathways should any patient attend that matched the admissions criteria on triage. These pathways were accessible seven days a week and included pathways for transient ischaemic attack, low risk chest pain, palpitations, acute headaches and first seizure admission pathway.

Is the service well-led?

Inspected but not rated

We have not rated well led as we did not inspect all the elements.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The emergency department senior leadership team operated as a triumvirate and consisted of two medical directors, a head of nursing and directorate lead. The triumvirate was supported by a further layer of leadership which consisted of an assistant director of nursing, matron, two assistant matrons, a deputy directorate lead, deputy directorate manager and an assistant deputy directorate manager.

The department followed RCEM guidance to have a consultant lead within the emergency department. The consultant lead for the department had completed a RCEM leadership course and carried out teaching of leadership for middle

grade doctors within emergency medicine. The nursing leadership team were seen to have extensive clinical and leadership experience. The Head of Nursing had undertaken postgraduate masters' qualifications in leadership, the Assistant Director of Nursing had completed a post graduate masters qualification in leadership and both carried out teaching of leadership for the senior nursing team with Emergency Medicine.

The leadership team were able to talk about the challenges the department faced which were staffing, patient demand and department capacity. The leadership team did understand the challenges that increased demand and lack of capacity had on the quality and sustainability of the service.

The leadership team had highlighted leadership and innovation, the workforce's resilience and response to COVID-19 and collaborative working throughout the trust as the emergency department's main successes over the past 12 months.

Each clinical shift in the emergency department was led by a lead consultant, who was supported by a team of consultants. The departments matron and assistant matrons all worked clinical shifts and carried a dedicated phone and could be contacted by staff at any point through their shift. The lead matron carried out a walkaround each day to provide leadership visibility and oversight and to provide reassurance to staff when the department was experiencing pressures. The matrons carried out two hourly walkarounds which included safety checklists.

The triumvirate had a manager of the day phone seven days a week and could be contacted by staff between 8am and 5pm. The triumvirate leadership team also carried out numerous visits to the department each day to support the teams.

We were told by leaders that a member of the executive team would visit the emergency department on a daily basis. Staff we spoke with told us leaders were visible within the department and that they felt they could raise concerns with them.

There was a consultant within the department every day, a consultant doctor would lead the morning handover and take handover of care from the night team and would plan with the day team how staff would be allocated to certain sectors of the emergency department. The lead consultant and nurse in charge for each shift coordinated care from the nurse station and were visible throughout the shift.

Culture

Staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work. The service had an open culture where patients, their families and staff could raise concerns without fear.

Leaders felt staff were respected, supported and valued. Leaders understood the challenges that staff faced and recognised their role included offering support and ensuring staff knew they appreciated their work. Leaders reviewed staff training and development and ensured that they were meeting targets for appraisals and personal development reviews so that staff were equipped with the correct skills and training to carry out their jobs.

Leaders spoke about the increased pressure the system was under; they understood the importance of celebrating the work that staff at the emergency department did. The department was under increased pressure due to its policy to ensure prompt ambulance handovers which in turn increased the number of patients in the department and demand on staff, however leaders felt that staff understood that this was necessary to reduce the risk to patients in the community.

Lead consultants told us that they had an open-door policy and that staff could come to them to raise any concerns they had. For staff who felt they did not have time to meet with the lead consultant team, they could email them to raise any concerns or ask for advice from the team.

The consultant team also invited speciality doctors and specialist grade doctors (SAS) to weekly consultant meetings and would encourage SAS doctors to present at those meetings so that they felt valued and listened to by the senior consultant team.

Leaders for the department believed in a culture of openness and understood that there was for need to have a no blame culture to ensure staff would raise when things had gone wrong. Leaders felt that staff who reported incidents were supported and tried to create a culture of learning from clinical incidents. The department tried to look at why an incident had happened and what actions could be taken to reduce the risk of it happening in the future. Leaders understood that the emergency department was under significant pressure and looked at how it could best support staff.

The medical and nursing team encouraged a culture of openness such as asking at handover had there been any incidents or issues during the previous shift, so that correct actions could be taken to ensure safe patient care.

The senior nursing team held meetings with the managers of the staff bank team as well as managers of nursing agencies to listen to concerns raised by staff. Leaders believed that information received from agency nurses was an important resource as they worked in many different departments and had good insight into how the department was working.

The head of nursing and staff freedom to speak up guardian held a monthly meeting within an area close to the emergency department which staff could attend confidentially and raise any concerns or issues. The emergency department matron held weekly one hour sessions called “time to talk Tuesdays”, which staff could attend and raise any concerns, if the matron was unable to hold the session due to sickness or annual leave then the assistant matron would hold the session.

Leaders reviewed sickness and staff absence weekly and understood the effect that the COVID-19 pandemic had on both staff's health and wellbeing. This was picked up in the weekly senior leadership meeting.

Leaders for the department told us that they had involved staff in suggestions and improvements for the department. The department held regular staff feedback groups for changes which had happened within the department and would make changes to the improvement processes following staff suggestions.

The department was scoping improvements for all areas of the emergency department and there was a staff team from each area who attended meetings and gave suggestions on what improvements could be made to each area to improve ways of working and patient care.

There was a display board which highlighted to staff the improvements and developments that were happening within the emergency department; however, staff had told leaders that they did not always have time to read this due to work pressures. Staff suggested to leaders that this information could be conveyed through a podcast that staff could listen to when they had time. Following this suggestion leaders had held meetings with the trust communications team to create a podcast for staff which was to be completed in the near future.

The department had developed multiple wellbeing initiatives, it had created a wellbeing retreat for staff which was not located in the department, this could be used by staff to take breaks. The trust provided frozen meals to staff so they could have warm meals on night shifts. There was a wellbeing team within the department who carried out massage therapy, wellbeing and mindfulness sessions, and mini health checks.

Staff were informed during their induction who the freedom to speak up champion was and how to contact them, the department also has an information board which displayed information on freedom to speak up and staff wellbeing. The freedom to speak up guardian visited the department monthly; they also took part in department walk around with senior management, so staff knew who they were and knew how to contact them.

Staff we spoke with told us that managers were both visible and approachable. Staff told us that the department was under a lot of pressure but said that they had raised these concerns to managers who had listened to them.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There was a NAPF team within the trust who would visit the department unannounced and inspect the department in line with the CQC key lines of enquiry to ensure the department was meeting clinical standards and performance targets.

The infection control team within the trust carried out unannounced spot audits throughout the year and the emergency department carried out its own monthly infection control and hand hygiene audits.

The department had a trust wide emergency care improvement programme board which met weekly, the improvement programme action plan was reviewed for progress and barriers to its completion. The Head of Nursing had an improvement action plan which looked at five core elements of patient care, quality and service delivery which were patient and staff harm free care, patient and staff experience, point of care complaints initiative called “tell me today”, transformational leadership and financial accountability.

The department had a risk register which fed into directorate, divisional and corporate level risk registers. Risks were graded and had action plans which were reviewed on a monthly basis by the head of nursing for the emergency department. The department also held a monthly governance meeting which was chaired by a lead consultant where risks and action plan progress were reviewed. This meeting was also used as an opportunity to review serious incidents which had occurred in the previous month and to check if the appropriate investigations had been carried out and ensure there was learning from them.

Leaders reviewed performance against national emergency care standards and had action plans in place to improve this. The senior leadership team for the urgent and emergency care directorate also held a monthly risk assurance panel which reviewed all the division’s highest graded risks and related action plans.

Each morning the leaders for the department held a meeting which looked at the current risks for the department such as patient demand, capacity and workforce gaps for the next 24 hours. This was followed by a trust wide bed meeting which looked at the trust’s access and flow risks over the next 24 hours. Issues such as staffing were also discussed at this meeting and staff could be requested from other wards within the trust to supplement staffing in the emergency department if required.

Urgent and emergency services

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

Royal Blackburn Teaching Hospital Urgent and Emergency Care department

- The trust must ensure that effective and timely care is provided; including at triage and assessment to improve patient access and the flow of patients through the emergency department and the hospital so that patients are treated and admitted or discharged in a safe, timely manner. (Regulation 12(1))
- The service must continue with plans to improve staffing levels for nurses to full establishment. (Regulation 18 (1))
- The service must ensure it maintains privacy and dignity for all patients who receive care within the emergency department. (Regulation 10 (1))

Action the trust SHOULD take to improve:

Royal Blackburn Teaching Hospital Urgent and Emergency Care department

- The service should ensure that continues to work closely with all system partners to tackle the capacity pressures on urgent and emergency care in the integrated care system.
- The service should continue to improve the staffing of its patient champion roles within the emergency department.
- The service should consider how it can improve facilities to meet the personal care needs.
- The service should ensure that cleaning schedules are completed appropriately.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two CQC team inspectors, and a CQC inspection manager.

The team reviewed data and information available before the site visit, and information sent from the trust.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing