Liverpool University Hospitals NHS Foundation Trust

Royal Liverpool University Hospital

Inspection report

Prescot Street
Liverpool
L7 8XP
Tel: 01517062000

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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 Liverpool University Hospital

Inspected but not rated

We carried out this unannounced focused inspection under our pressures resilience five (PR5) focused inspection guidance.

We took into account nationally available performance data and concerns we had received about the safety and quality of the services. We inspected against the safe, responsive and well-led key questions. We inspected key lines of enquiry relevant to the pressures resilience five programme. We also inspected the trusts response to conditions imposed on their registration following our last inspection.

We inspected the urgent and emergency services and medical care core services during this inspection.

We did not inspect surgery because the services had not had time to make the improvements necessary to meet legal requirements as set out in the action plan the trust sent us after the last inspection. We are monitoring the progress of improvements to services and will re-inspect them as appropriate.

Urgent and emergency services and medical care services at Royal Liverpool Hospital are provided by Liverpool University Hospitals NHS Foundation Trust. The trust was created on 01 October 2019 following a process of acquisition, in which Aintree University Hospital NHS Foundation Trust acquired Royal Liverpool and Broadgreen Hospital NHS Trust.

We visited University Royal Liverpool Hospital as part of our unannounced inspection from 22 March to 24 March which included the emergency department , acute medical assessment unit and the discharge lounge. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

A summary of CQC findings on urgent and emergency care services in Cheshire and Merseyside (Liverpool, Knowsley and South Sefton).

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 Liverpool, Knowsley and South Sefton within the Cheshire and Merseyside ICS below: Cheshire and Merseyside (Liverpool, Knowsley and South Sefton)Provision of urgent and emergency care in Cheshire and Merseyside 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 had continued to work hard under sustained pressure across health and social care services.

Services had put systems in place to support staff with their wellbeing, recognising the pressure they continued to work under, in particular for front line ambulance crews and 111 call handlers. Staff and patients across primary care reported a preference for face to face appointments. Some people reported difficulties when trying to see their GP and preferred not to have telephone appointments. They told us that due to difficulties in making appointments, particularly face to face, they preferred to access urgent care services or go to their nearest Emergency Department. However, appointment availability in Cheshire and Merseyside was in line with national averages.

Our findings

We identified capacity in extended hours GP services which wasn't being utilised and could be used to reduce the pressure on other services. People and staff also told us of a significant shortage of dental provision, especially for urgent treatment, which resulted in people attending Emergency Departments. Urgent care services, including walk-in centres were very busy and services struggled to assess people in a timely way. Some people using these services told us they accessed these services as they couldn't get a same day, face to face GP appointment. We found some services went into escalation. Whilst system partners met with providers to understand service pressures, we did not always see appropriate action taken to alleviate pressure on services already over capacity.

The NHS 111 service, which covered all of the North West area including Cheshire and Merseyside, were 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 (OOH) provider. We found some telephone consultation processes were duplicated and could be streamlined. At peak times, people were waiting 24-48 hours for a call back from the clinical assessment and out of hours services. We identified an opportunity to increase the skill mix in clinicians for both the NHS 111 and the clinical assessment service. For example, pharmacists could support people who need advice on medicines. Following our inspections, out of hours and NHS 111 providers have actively engaged and worked collaboratively to find ways of improving people's experience by providing enhanced triage and signposting. People who called 999 for an ambulance experienced significant delays.

Whilst ambulance crews experienced some long handover delays at the Emergency Departments we inspected, data indicated these departments were performing better than the England average for handovers, although significantly below the national targets. However, crews found it challenging managing different handover arrangements at different hospitals and reported long delays. Service leaders were working with system partners to identify ways of improving performance and to ensure people could access appropriate care in a timely way. For example, the service worked with mental health services to signpost people directly to receive the right care, as quickly as possible.

The ambulance service proactively managed escalation processes which focused on a system wide response when services were under additional pressure. We saw significant levels of demand on emergency departments which, exacerbated by staffing issues, resulted in long delays for patients. People attending these departments reported being signposted by other services, a lack of confidence in GP telephone appointments and a shortage of dental appointments. We inspected some mental health services in Emergency Departments which worked well with system partners to meet people's needs. We found there was poor patient flow across acute services into community and social care services. Discharge planning should be improved to ensure people are discharged in a timely way. Staff working in care homes (services inspected were located in Liverpool and South Sefton)reported poor communication about discharge arrangements which impacted on their ability to meet people's needs.

The provision of primary care to social care, including GP and dental services, should be improved to support people to stay in their own homes. Training was being rolled out to support care home staff in managing deteriorating patients to avoid the need to access emergency services. We found some examples of effective community nursing services, but these were not consistently embedded across social care. Staffing across social care services remains a significant challenge and we found a high use of agency staff. For example, in one nursing home, concerns about staff

Our findings

competencies and training impacted on the service's ability to accept and provide care for people who had increased needs. We found some care homes felt pressure to admit people from hospital. Ongoing engagement between healthcare leaders and Local Authorities would be beneficial to improve transfers of care between hospitals and social care services.

In addition, increased collaborative working is needed between service leaders. We found senior leaders from different services sometimes only communicated during times of escalation.

Urgent and emergency services

Inspected but not rated

We visited Royal Liverpool Hospital as part of our unannounced inspection from 22 March to 24 March which included the emergency department. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

The urgent and emergency care services at Royal Liverpool Hospital form part of the medicine division. Emergency care is provided 24 hours a day, seven days per week and primarily serves the population of Liverpool and the wider Merseyside area. The service is not a designated children's hospital but any child patients attending the department are signposted or stabilised and transferred to a neighbouring NHS children's trust.

At the last inspection in June 2021, the emergency department at Royal Liverpool Hospital was rated Inadequate. We placed conditions on the trust's registration to improve practice.

As part of this inspection, we observed care and treatment of patients in triage and treatment areas including those receiving care on a main corridor within the department. We looked at 24 care records. We spoke to five patients. We also spoke with 12 staff members across the department including staff nurses, senior nurses, a pharmacist, consultants, health care assistants, matrons, service managers, and members of the executive team.

We did not rate the core services at this inspection. The previous rating of requires improvement remains.

See urgent and emergency care section for what we found.

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, and managed safety well.
- The service controlled infection risk well.
- Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- 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 felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.

However:

- The service needed to improve the levels of staff who had undertaken level three safeguarding training to ensure staff understood how to protect patients from abuse.
- The service needed to maintain a continued focus on improvement activity to ensure the proper and safe management of medicines.
- Although people could access the service, waiting times for treatment were not within national targets.
- We noted that the service risk register identified inadequate access to cardiac arrest emergency buzzers in resus due to ongoing estates work. This meant that could potentially be put at risk during a cardiac emergency.

Urgent and emergency services

How we carried out the inspection

We inspected the urgent and emergency care service at Royal Liverpool Hospital on 22 and 23 March 2022. This was an unannounced inspection (the trust did not know we were coming).

During the inspection we spoke with 18 staff members, three people who worked for other organisations, attended two meetings and checked 10 sets of patient records.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

The team that inspected the service comprised a CQC lead inspector, and two other CQC inspectors assisted by a specialist advisor emergency department consultant and a CQC inspection manager. The inspection team was overseen by Karen Knapton, Head of Hospital Inspection.

Is the service safe?

Inspected but not rated

Safeguarding

There were systems, processes and practices to keep people safe identified in place. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing and medical staff received adult and children's safeguarding training specific for their role on how to recognise and report abuse.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff told us that they would escalate concerns to the lead nurse, safeguarding lead and report on the appropriate system.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The patient record system prompted staff to consider the risk of safeguarding vulnerability and known vulnerable patients were flagged on the system with details of concerns.

The patient record system alerted staff if an attending child was on the at risk register though few children attended the department as patients as there was no paediatric emergency department at the hospital. Patients under the age of 18 were flagged on the system so staff could take appropriate action in transferring them to the paediatric emergency department in a neighbouring children's hospital and make checks on the child protection information sharing system.

Training included PREVENT which is a part of the government's overall counter-terrorism strategy to reduce the threat from terrorism by stopping people becoming terrorists or supporting terrorism.

Training also included elements on female genital mutilation (FGM) and child sexual exploitation.

Urgent and emergency services

We reviewed the completion rates for nursing staff and health care assistants for level one, two and three adults and children's safeguarding courses.

Until July 2021 there was only a requirement for senior nurses in the department to have level three safeguarding training. This was now mandatory for all nursing staff and healthcare assistants, so level three training compliance was much lower than the expected target compliance of 88%. We saw that 87% of staff had completed level one training in adult and children's safeguarding. Level two safeguarding adults had been completed by 80% of staff and level two safeguarding children had been completed by 79% of staff. Level three safeguarding adults had been completed by 47% of staff and level three safeguarding children by 30% of nursing staff and healthcare assistants. There was a focus on completion of level three training for staff to meet trust completion targets.

Training on domestic abuse had also been extended to healthcare assistants. This ensured that staff were able to complete the Merseyside Risk Identification Tool (MeRIT) and refer the patient to the safeguarding team where there was a suspicion of domestic abuse. Staff had received appropriate training so they were able to identify high risk cases of domestic abuse, stalking and potential "honour" based violence victims and identify which patients needed to be referred to a multi-agency risk assessment conference (MARAC) and what other support may be required.

There was a safeguarding team who provided in-reach into the department. Managers told us that staff were comfortable in reporting concerns to the safeguarding team and that all levels of staff were encouraged to report concerns.

There were identified safeguarding leads in the department who were trained to level four. The trust had a lead nurse and a lead doctor for safeguarding.

The trust had a range of safeguarding policies and procedures in place, including safeguarding adults at risk of abuse policy; safeguarding children and young people policy; female genital mutilation procedures; domestic abuse procedures; mental capacity act policy and deprivation of liberty policy. There was also a safeguarding strategy, but this was dated 2018 to 2021 and it was not clear whether it had been updated.

Any safeguarding information about individual patients was passed on during handover. The handover document contained a section about patients in the department where there was a safeguarding concern. The department also had a colour coding scheme on cubicles using coloured boxes. The box indicating safeguarding was ticked for those patients where there were safeguarding concerns.

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 were clean and had suitable furnishings which were visibly clean and well-maintained.

The service generally performed well for cleanliness. Social distancing reminders were in place throughout the department, including, posters, signs and floor markings. However, during our inspection, we observed overcrowding in the waiting room which meant people attending the department were unable to adequately socially distance themselves from others. Improvement works had been undertaken in the emergency department, however, these were not related to the waiting room. Whilst the current footprint would not allow an expansion, the waiting room in the new Royal Liverpool Hospital was planned to be larger in size.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

We saw that infection prevention and control risks were discussed at handovers.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Staff cleaned equipment after patient contact. We saw that labels to show when equipment was last cleaned were readily available in the department but were not being widely used so not all staff could know when something had last been cleaned.

The matron carried out monthly audits on infection prevention and control. The hand hygiene report showed that compliance at 95% on 5 March, 90% on 11 March and 89.4% on 18 March 2022.

The infection prevention and control audits for March 2022 showed 70% compliance and for February 2022 showed 74% compliance. Issues cited in the audits were a lack of compliance in wearing visors and some doctors and visiting speciality staff wearing masks below the nose or mouth when working at a desk or on the telephone. There was an action plan in place to improve compliance with the wearing of PPE correctly.

We observed that all staff were bare below the elbow and wearing appropriate PPE, however we did see one member of staff with their mask pulled down to their chin whilst on the telephone. Staff changed aprons and gloves between patients and washed and sanitised their hands.

We saw that the majors and resus areas displayed certificates which showed that they had five-star rating in cleanliness (valid to 29 March 2022).

The environment was clean and dust free. Chairs and beds were covered in a wipeable material. Disposable curtains were in good repair, were clean and had valid date stamps.

We observed that cubicles were deep cleaned once vacated and ‘locked’ to prevent use when awaiting cleaning.

Most toilets were clean, although we noted that the toilet in the mental health room had not been flushed and there was some litter on the floor in the room. We raised this with the staff and were advised that the room is usually cleaned as soon as it is vacated.

Since our last inspection in June 2021, the department had undergone building work to improve infection prevention. In majors and resus, the cubicles all now had solid walls and sliding doors rather than curtains.

Cubicles occupied by patients with infectious or contagious conditions were clearly identified with posters and symbols, for example, we saw several with a ‘droplet’ status poster on the cubicle door. Staff were familiar with the various symbols in use to denote risk of infection or airborne droplets.

The clean utility room was neat and tidy with all consumables etc clearly labelled and a sample check showed that everything was in date.

Urgent and emergency services

We saw that some seats had been removed from the main emergency department waiting room to maintain social distancing and protect patients from infection. Hand sanitiser and face masks were available to patients in the waiting room though we observed that not all patients or their relatives and friends were wearing face masks whilst waiting to be seen.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The designated mental health room (section 136 room) within the department was appropriately, furnished, lit and decorated. The room was well laid out with no blind spots. The seating had recently been changed to wider couches to allow patients to lie down. This seating was along two walls and fixed so that no part could be removed. The seat pads were secured and easily cleaned. There were no viewing panels in the doors however, there was CCTV in the room and patients were always supervised.

There were no ligature points, and the room was designed to minimise risk of self-harm. There was an En-suite bathroom off the room.

The room was situated away from the main departments however was close to the ambulance entry door and the corridor outside was full of trolley waits with some trolleys obstructing easy access to the door of the 136 room at times.

Patients in cubicles in the department could reach call bells and staff responded quickly when called. The design of the environment followed national guidance.

The service had enough suitable equipment to help them to safely care for patients.

Staff carried out daily safety checks of specialist equipment. We saw that although there was a lot of equipment around the department it was stored against the walls and cables were secured to prevent any trip hazards.

There was equipment available in the department to enable the assessment of patients with presumed sepsis or other clinical emergencies, including pulse oximeters; blood pressure machines and thermometers.

Resuscitation equipment (including medicines, oxygen and defibrillators) was available and fit for purpose. It was adequately stocked and there was evidence that the resuscitation trolleys were checked daily.

Equipment checked had valid electrical safety check stickers. The service had suitable facilities to meet the needs of patients' families.

Staff disposed of clinical waste safely. Pedal bins were clearly identifiable as to what their use was for and had foot operate pedals which worked. However, we did note that one bin in the corridor used for trolley waits was left in the open position and was very full.

However;

We noted that the service risk register identified inadequate access to cardiac arrest emergency buzzers in resus due to ongoing estates work. This meant that could potentially be put at risk during a cardiac emergency.

Urgent and emergency services

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.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. The department had introduced a new patient safety checklist to ensure that appropriate risk assessments were completed for each patient on arrival in the department and each hour thereafter and specific pathways were triggered and commenced with speciality referrals made as required.

All walk-in patients to the emergency department were given a rapid assessment by a senior nurse at reception. Any patients identified as high risk, for example with chest pain or breathing difficulties were escalated immediately for further triage or ECG assessments.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. A national early warning score (NEWS2) was assessed for each patient at initial triage. NEWS2 scores were audited to ensure that patients had been triaged appropriately.

Patients were given a secondary triage based on order of acuity before being directed to the most appropriate area in the department. All patients were swabbed at the earliest opportunity for a rapid Covid-19 test so appropriate isolation facilities could be provided for those patients who tested positive.

Staff knew about and dealt with any specific risk issues. For example, staff carried out pressure area risk assessments and used a body map and the “react to red” process. Tissue viability nurses assessed the patient where possible. Sepsis screening tools were in place as were assessments for risk of falls or venous thromboembolisms. There was a sepsis trolley in the department so that sepsis treatment could be initiated quickly. Trust data showed 72% of patients with suspected sepsis received antibiotics within 1 hour, against a target of 90% [Quarter 3 2021-22].

We reviewed ten sets of patient records and saw that appropriate risk assessments and observations had been carried out for each patient. The electronic patient board in the department gave a clear indicator of when patient observations were due to be completed.

The service had 24-hour access to mental health liaison and specialist mental health support. (If staff were concerned about a patient’s mental health).

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

Ambulance handover records showed that patients were being handed over and clinically assessed within around 25 minutes of arrival and ambulances were able to clear the department to attend another call within around 36 minutes. In the week commencing 21 March 2022, the average ambulance turnaround time (time of arrival to clearing the site) was 36.06 minutes. On the day of our inspection the percentage of ambulance attendances that were taking 30-60 minutes to hand over was 10.1% against an England average of 14.6%. This was consistently lower than the England average. The percentage of ambulance attendances that were taking more than 60 minutes to hand over was 4.1% against an England average of 11.1%.

Ambulance crews told us that they did not have to hold patients in ambulances outside the department.

Staff shared key information to keep patients safe when handing over their care to others. There were two hourly safety huddles between the nurse in charge, lead consultant and departmental manager. They discussed category one and two patients, those with raised NEWS2 scores and identified priority patients. The consultant's attendance at the safety huddle was monitored through the monthly operations and performance dashboard and we were told that it was only on rare occasions where they did not attend the huddle.

Shift changes and handovers included all necessary key information to keep patients safe.

All senior nursing staff had paediatric life support training and there was always someone on duty with advanced paediatric life support certification.

Approximately 80% of staff had basic life support training accreditation. The trust target was 88%.

Nurse staffing

The service had 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, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The department manager could adjust staffing levels daily according to the needs of patients. The department used the emergency care safer care nursing tool to plan staffing. The department had conducted workforce modelling and planning to meet the new increase in demand and were planning staffing numbers for the move into the new Royal Liverpool Hospital site later in 2022 which meant that the increase in size of department would require an increase in the number of staff.

The service had no vacancies. There were 35 band six nurses; 14 band seven nurses and six band four staff employed. This matched planned numbers. There were 61 band five nurses in post against the planned number of 58.6. The department had authority for over establishment of band five nurses up to 10 which would allow an extra 10,000 patients per year to be seen in the department. There was a rolling job advertisement for band five nurses to work in the department.

The number of nurses and healthcare assistants did not always match the planned numbers. The service operated a system of staffing gaps per shift meeting gold, silver, bronze, or red standards. The gold standard was met if there were no staffing gaps, bronze was met if there were minimum (worst case scenario) nursing staff on shift and red was classed as unsafe staffing levels. Managers told us that the department always aimed for gold staffing levels and had never had to operate with unsafe staffing levels as they always managed to pull in staff from other departments and bring in bank staff at short notice if required.

The planned gold standard staffing levels for the department were for 18 registered nurses on the early shift (plus one phlebotomist and one senior nurse in charge); 19 registered nurses on the late shift (plus three phlebotomists and one senior nurse) and 18 registered nurses on the night shift (plus one senior nurse). There was a gold standard to have nine healthcare assistants on each shift.

The bronze standard (minimum safe staffing levels on each shift was for 16 registered nurses).

We saw that on 22 March 2022, during our inspection, on the early shift there were only 13 registered nurses and five healthcare assistants; on the late shift there were only 14 registered nurses and three healthcare assistants and on the night shift there were only 15 registered nurses and five healthcare assistants.

This was mainly due to short notice sickness absence with a high prevalence of Covid-19 sickness in the community and workforce. Staff were encouraged to report their non-attendance at the earliest opportunity so that arrangements could be made to fill staffing gaps. The department had managed to fill the staffing gaps to a minimum staffing level by bringing in staff from other departments and use of bank staff. There were clear escalation plans in place to fill staffing gaps.

We saw that the matron and lead nurse assisted and undertook clinical work throughout the day at busy periods in the department and ensured that staffing was kept at a safe level in each area of the department.

The service had low and/or reducing turnover rates. The turnover rate for February 2022 was 1.75%. The rolling rate over the year was 23.93%. The department had not been identified as a staff turnover hotspot within the trust.

The service had low and/or reducing sickness rates. The sickness rate for February 2022 was 4.94%.

The service had low and/or reducing rates of bank and did not use agency nurses. They also made use of staff overtime.

Managers limited their use of bank staff and requested staff familiar with the service.

Managers made sure all bank staff had a full induction and understood the service.

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.

We requested the planned number of medical staff at different grades against the actual number but did not receive this so it was not possible to determine what the establishment of medical staffing should be.

Managers told us that, since our last inspection, there had been significant investment in medical staffing in the department.

There were emergency medicine and trauma consultants in the department 16 hours per day from 8am to 2am, which is in line with RCEM guidance. Outside of these hours there were consultants on call.

The planned number of medical staff was for: two consultants on shift from 8am to 6pm; one consultant on shift from 5pm to 10pm; one on shift from 5pm to 11pm plus on call thereafter; and one consultant on shift from 6pm to 2am plus on call thereafter. In addition. there were two registrars on shift; 10 junior doctors; one advanced nurse practitioner and two emergency nurse practitioners. We saw that the planned number of staff were on shift during our inspection.

The service had low and/or reducing vacancy rates for medical staff. The service also had low and/or reducing turnover rates for medical staff. Data showed that Sickness rates for medical staff were low and/or reducing.

Urgent and emergency services

The service had low and/or reducing rates of bank and locum staff. Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work. The service had a good skill mix of medical staff on each shift and reviewed this regularly.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Following our previous inspection, the trust was taking action to improve the safe prescribing of gentamicin. Actions including education, trust formulary review to reduce gentamicin use and greater oversight of prescribing and monitoring, had led to a reduction in recorded incidents of 63% [period August 2021 to November 20211, compared with April 2021 to July 2021]. A continued focus on safe use of gentamicin was included in the trust's Medicines Safety Improvement Plan.

Trust data showed 68% of patients with suspected sepsis received antibiotics within 1 hour, against a target of 90% [Quarter 3 2021-22].

We observed the medicines room in the resus department and found it to be cluttered with electrical medical equipment. Staff told us there was limited space within the department. We found one member of staff preparing an intravenous antibiotic in the corridor on the patient's notes trolley and we could not be sure this was a clean surface area.

Emergency medicines were securely stored in the resus department, but daily checks were not being completed. We found incorrect strengths of one medicine in the resus bags, which may have increased the risk of a drug administration error. A trolley containing intravenous fluids was broken, which meant they were not being stored securely.

On discharge, medicines had to be manually added to the electronic discharge letter, and trust data showed that 24% were not sent to GPs within the target 24 hours [March 2022]. This meant there may have been delays in updating patients' records when they move between services.

Is the service effective?

Inspected but not rated

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

During our last inspection, in June 2021, national audit submissions, such as Trauma Audit and Research Network (TARN) and the Royal College of Emergency Medicine (RCEM) audit had been suspended during the COVID-19 pandemic and there was limited oversight of the department's performance and opportunity to improve the service provided.

The service now participated in relevant national clinical audits.

Urgent and emergency services

Outcomes for patients were positive, consistent and met expectations, such as national standards. We reviewed the Trauma Audit and Research Network and saw that the rate of survival for patients arriving with trauma injuries who were expected to survive, was almost 100% from 2019 to 2021. However, the audits on brain and skull injuries over the same period showed that, of the 19 patients who had a computed tomography (CT) scan, the average time to receiving the scan was 1.27 hours against a national target of less than one hour and a national average of 0.57 hours.

The last Sentinel Stroke National Audit Programme (SSNAP) audit was published in 2019. There were 10 key indicators around how stroke services were organised in a hospital. Two of the key indicators were relevant to the emergency department. The department met the indicator for having stroke specialist nurses who undertook hyper-acute assessments of suspected stroke patients, out of hours and seven days a week. It also met the indicator for pre-alerting a stroke nurse for all stroke patients being brought in by an ambulance crew.

The trust also confirmed that they were again submitting data for Healthcare Quality Improvement Partnership (HQIP) and the Royal College of Emergency Medicine (RCEM) audits.

Managers and staff used the results to improve patients' outcomes. Managers and staff carried out a programme of repeated audits to check improvement over time. Managers used information from the audits to improve care and treatment. Improvement was checked and monitored.

Is the service responsive?

Inspected but not rated

Access and flow

People could access the service when they needed it. However, waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards. The service was not meeting national standards to admit, treat, transfer or discharge patients within four hours. However, this was an improving picture despite increasing numbers of patients coming into the service.

In the 12 months prior to our inspection (March 2021 to March 2022) the department had 126,758 attendees with a median time from arrival to treatment of 129 minutes. The number of attendances resulting in admission to the hospital was 26,696 (21.1%).

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 A&E (Accident & Emergency). The trust achieved 79.1% compliance rate at the time of our inspection against an England average of 71.3%. The trust achieved 78.2% compliance for this performance indicator in March 2022. For Type one A and E attendances this figure was 60.5% against an England average of 61.9%. The trust achieved 59.9% compliance for this performance indicator in March 2022.

The percentage of type one attendances treated within 60 minutes of arrival into the department was 25.7% against an England average of 31.3% at the time of our inspection. For March 2022 overall, this figure was 29.2%.

We saw that the trust had a consistently higher number of attendances that were majors than the England average and a consistently lower number of attendances that were “minors” patients than the England average.

Urgent and emergency services

We saw that the short and long-term plans for the department had all been developed with the flow of patients through the department in mind. The new Royal Liverpool Hospital would provide a bigger department and we were told this should enable better access and flow. The trust had planned the number of staff needed within the emergency department in the new hospital and how access and flow could be maximised.

Streaming of patients into and through the emergency department began at the front door. Patients were seen and rapidly triaged by a nurse at reception who booked their details onto the records system and streamed them for secondary triage according to acuity. Patients received a comprehensive assessment with clear clinical care pathways and protocols to help standardise and ensure evidence-based care is provided.

There was an escalation process in place that used action cards so that additional support could be provided when the department and waiting area became busy. There were four levels in the escalation plan with clear actions that should be undertaken for each level and an identified lead such as consultant in charge; nurse in charge; matron; lead nurse and head of operations.

Managers and staff worked to make sure patients did not stay longer than they needed to.We saw that there was monitoring of the electronic patient dashboard, showing the number of patients in each part of the department so that concerns about increasing numbers of patients could be escalated at the earliest opportunity. There was a constant focus on ensuring that admittance and discharge was carried out as soon as possible. Staff were kind, respectful and compassionate to people and gave them clear information about how long they would remain in the department.

Staff supported patients when they were referred or transferred between services. Managers monitored patient transfers; however, they did not consistently follow national standards. The department had a commitment to transferring patients to more suitable services and specialities as soon as possible when the day shift began. The manager of the day, a senior nurse, identified five patients that were suitable for GP assessments and five people who required attendance for tests in the ambulatory emergency care unit by 10AM each morning. This was known as “10 by 10”. In addition, every morning, six specialities identified five patients each in the department to be transferred to them for ongoing care and treatment as soon as possible. This meant that up to 40 patients could be moved out of the department every morning.

The hospital now operated an electronic system called “silent handover” that alerted ED staff on the patient dashboard that a bed was ready for individual patients. Patients could be prepared and made ready to be admitted from ED when the bed became available. Prior to this system coming online, managers told us that staff could spend 30 minutes or more trying to phone a ward to find out whether a bed was available. Patients could now be transferred out of the department within 30 minutes of bed becoming available.

There were several bed meetings each day. We observed two bed meetings and saw that there were clear messages about capacity within the hospital and the numbers of patients that needed to be admitted from the emergency department. There were clear messages about when patients would be discharged and good communication between departments so that there was a clear picture of the overall situation. At the time of our inspection, bed capacity was at 95% and above, which is above the optimum level, and had been for some time. Despite, this, we saw that patients were moved out of the emergency department and admitted as soon as a bed became available.

The number of patients leaving the service before being seen for treatments was fairly high at 14.7%. The number of people who left the department having refused treatment was low at 0.7%.

Urgent and emergency services

Managers and staff started planning each patient's discharge as early as possible. Staff planned patients' discharge from the department carefully, particularly for those with complex mental health and social care needs.

Is the service well-led?

Inspected but not rated

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. They supported staff to develop their skills and take on more senior roles.

The emergency department was part of the trust's medicine directorate. From early 2022 the trust had introduced a hospital leadership team for each of the hospitals in the trust to provide stronger operational site management as well as the directorate and specialty cross-trust management structures. The hospital was led by a medical director, nursing director and operational director.

The emergency department was led by a medical lead consultant, an operational lead and two lead nurses, supported by three matrons.

We saw that that senior leaders within the department were very visible and they undertook clinical shifts. Staff reported that they were supportive and approachable.

Trust executives had visited the department to support staff and were able to describe the positive changes in the department.

Leaders in the department had access to leadership training.

The leadership team were well-sighted on the challenges and risks to the department and had worked cohesively to develop a transformation programme for the emergency department. We saw that they had clear expectations of how other teams should support the emergency department in times of surge and that this was becoming embedded.

Staff told us that leaders were visible and approachable and that they felt well-supported.

We saw that the lead nurses reacted quickly and responsively to surges in patients entering the department and to mitigate short notice staffing shortages.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us that they felt the team were all well supported and that everyone worked well together. Managers were visible on the floor and the matrons and lead nurses all helped out when they were needed. Doctors took on additional duties when nurses needed to be moved to cover staffing gaps.

Staff felt they could approach doctors and consultants for advice and did not feel they would be judged for asking questions or making suggestions. Consultants and doctors would work with the nurses to help with flow.

Speciality doctors from other departments worked well with the emergency department staff to take patients from the department and improve flow.

The leadership team supported innovation for example, they had adopted the suggestion of using coloured icons on cubicle doors to indicate potential patient risks and status.

Posters were seen within the department advising staff how to report concerns via freedom to speak up guardians. Staff were encouraged to raise concerns or suggestions for improvements.

There were quick response (QR) codes in the department that staff could use to take them to an anonymous questionnaire where they could give feedback.

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 an embedded culture of identifying, reporting and mitigating risks within the department. There was a departmental risk register in place. We saw that managers were well-sighted on the main risks in the department.

There were 21 current risks on the risk register for the department. We saw that each risk had a risk manager and risk owner, there was a summary of controls in place, next review date and a series of actions to mitigate the risk.

The highest risks on the register were:

- acute unwell patients being admitted from the emergency department to the escalation ward due to a lack of leadership and structure not yet in place or agreed;
- delay in inpatient discharge due to lack of community capacity, resulting in extended patient stays and delays in the emergency department.
- Inadequate access to cardiac arrest emergency buzzers in resus due to ongoing estates work;
- And the demands on the emergency departments impacting on the division's ability to provide timely and effective care.

Of the risks on the register the department judged that two risks were fully under control; the risk was adequately controlled (16 risks) and action to control the risk adequately had started and appeared to be effective (three risks).

Managers had carried out a lot of quality improvement work to mitigate the risks and this was ongoing. There was an improvement plan in place.

New improvements were being brought online on a regular basis to improve the flow of patients through the department.

Urgent and emergency services

The emergency department underwent a monthly performance review with the executive team to review performance across a range of metrics, such as workforce, quality outcomes, finance and performance standards.

Leaders in the department were well-sighted on financial pressures that may compromise care.

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:

Liverpool Royal Infirmary – Urgent and emergency care

The trust must ensure a continued focus on improvement activity to ensure the proper and safe management of medicines

The trust must ensure staff have completed BLS (Basic Life Support) in line with trust targets

Action the trust SHOULD take to improve:

Liverpool Royal Infirmary – Urgent and emergency care

The trust should ensure that staff complete level three safeguarding training for adults and children to meet the expected target compliance.

The trust should consider using the labels that are available in the department to show when items and areas had been cleaned.

The trust should review the current security of medicines and the checks in place to ensure the proper and safe management of medicines

The trust should ensure cardiac arrest emergency buzzers are available across the department.

Medical care (including older people's care)

Inspected but not rated

We visited Royal Liverpool Hospital as part of our unannounced inspection from 22 March to 24 March 2022 which included the Acute Medical Unit [AMU] and the Discharge Lounge. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

- Staff understood how to protect patients from abuse. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records.
- Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.
- Staff provided good 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. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions.
- 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 and supported staff to develop their skills. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

However:

- The service did not always have enough staff to care for patients and keep them safe.
- Staff we spoke reported delays associated with the completion of the revised Healthcare Needs Assessment (HNA).
- People could routinely access the service when they needed, however they did not always receive the right care promptly**.**
- Managers did not robustly monitor the number of patients whose discharge was delayed and took action to prevent delays.
- Patients often had long waits in the discharge lounge.

Is the service safe?

Inspected but not rated

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

There were clearly defined and embedded systems, processes and standard operating procedures to keep people safe and safeguarded from abuse, using local safeguarding procedures whenever necessary. Nursing staff received training specific for their role on how to recognise and report abuse. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Medical care (including older people's care)

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff followed safe procedures for children visiting the acute medical [AMU] ward.

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. Both areas we visited, and equipment we observed were visibly clean and had suitable furnishings which were clean and well-maintained. Social distancing reminders were in place throughout both the Acute Medical Unit [AMU] and the Discharge lounge, including, posters, signs and floor markings. There were stations for donning and doffing of PPE, bins were not overflowing and were observed to be clean. Sharps bins were dated, not overfilled and closed when not in use.

Staff followed infection control principles including the use of personal protective equipment (PPE). PPE was available in all clinical areas.

Patients who were COVID-19 positive or who had contracted a communicable disease were nursed in single rooms, there was clear signage to indicate the risk of infection and the need to wear appropriate personal protective equipment.

We reviewed cleaning records, on both the AMU and Discharge lounge and noted that they were up-to-date and demonstrated that all areas were cleaned regularly.

Staff told us that domestic staff could be called to complete additional cleaning as required.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Both AMU and the Discharge Lounge, had enough equipment to safely care for patients. We looked at five pieces of equipment and records for a further 53 and found these were in date for servicing and maintenance.

Staff carried out daily safety checks of specialist equipment. Resuscitation trolleys were checked daily. We reviewed five checklists from the resuscitation trolley and each had been completed appropriately.

We reviewed a sample of three pieces of emergency equipment such as defibrillator, suction machine and blood pressure monitor which all had stickers to indicate that they had maintenance checks in the last 12 months.

During our inspection we observed staff disposing of clinical waste. Staff disposed of clinical waste appropriately, we noted that areas where clinical waste was stored were visibly clean and well organised.

Patients told us they could reach call bells and staff responded quickly when called.

Assessing and responding to patient risk

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

Medical care (including older people's care)

Risks to people who used services were assessed, monitored and managed on a day-to-day basis. These included signs of deteriorating health, medical emergencies, or the management of people with challenging behaviours. Staff used a nationally recognised tool (NEWS2) to identify deteriorating patients and escalated them appropriately. Records we saw during this inspection showed NEWS2 had been completed in accordance with recommendation and concerns had been escalated correctly.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed 10 patient records in AMU and three on the Discharge Lounge and observed practice in both departments over two days. None of the records we reviewed showed significant delays in relation to risk assessments, patients monitoring or the delivery of care and treatment. For example, managers carried out a programme of repeated audits to check improvement over time. AMU carried out audits on the completion of NEWS (National Early Warning Score) documentation completion. Over the previous three months prior to inspection, AMU had achieved an average of 98% compliance.

Staff generally shared key information to keep patients safe when handing over their care to others. However, staff told us that at peak times when the AMU and discharge lounge where full, there had been issues regarding the quality of the information shared. For example, we were told that there had been complaints from patients' relatives and care providers that the discharge summaries for specific patients lacked key details. We reviewed the service risk register and noted that discharge summaries were listed as an ongoing risk. Senior leaders told us that they were aware this was an issue and work was being undertaken to address the issue.

Where relevant, there were effective handovers and shift changes to ensure that staff could manage risks to people who used services. We observed that shift changes and handovers included all necessary key information to keep patients safe.

Nurse staffing

The service did not always have enough nursing 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.

The service did not always have enough nursing and support staff employed to keep patients safe. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Managers calculated the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. However, we noted that the number of nurses and healthcare assistants did not always match the planned numbers. The trust board report from March 2022 highlighted that the trust wide AMU team, had reported 167 episodes of absence in one month.

The service operated a system of monitoring the risk of staffing gaps per shift, and whether the wards met gold, silver bronze or red standards. The gold standard was met if there were no staffing gaps, bronze was met if there were minimum (worst case scenario) nursing staff on shift and red was classed as unsafe staffing levels. On inspection we noted that between the 14 to the 18 of March 2022 there had been consistent gaps in staffing, which had been filled by bank or agency staff. Managers told us that they made sure all bank and agency staff had a full induction and understood the service. Managers stated that they limited their use of bank and agency staff and requested staff familiar with the service whenever possible.

Medical care (including older people's care)

Medical staffing

The AMU did not consistently have enough medical staff with the right qualifications, skills, training and experience to be compliant with national guidance. However, due to consultants working overtime and the flexibility of other grades of medical staff, patients were kept safe from avoidable harm.

The service always had a consultant on call during evenings and weekends. The consultant on call at weekends and evening was supported by a registrar and junior doctors. Data from May 2022 shows the ratio of consultant to non-consultant doctors was 0.85 this is above the national average of 0.71.

Managers told us that sickness rates for medical staff were reducing. Managers could access locums when they needed additional medical staff. Managers said they made sure locums had a full induction to the service before they started work. We reviewed the induction package for locum doctors and noted that it covered key areas such as gaining access to places and systems, a physical orientation of the setting and information on test requests, clinical pathways, referral pathways, discharge processes, and how to access specific hospital policies.

Medicines

The service did not always use systems and processes to safely prescribe, administer and record medicines.

On discharge, medicines had to be manually added to the electronic discharge letter, and trust data showed that 24% were not sent to GPs within the target 24 hours [March 2022]. This means there may have been delays in updating patients' records when they moved between services and patients may not have received some medications in a timely way.

Medicines safe storage and controlled drugs [CD] checks were audited monthly. Trust data from October to December 2021 showed some improvement although this was below the 90% target. A task and finish group had been set up to review issues of medicines management.

Is the service effective?

Inspected but not rated

People have comprehensive assessments of their needs, which include consideration of clinical needs (including pain relief), mental health, physical health and wellbeing, and nutrition and hydration needs. The expected outcomes are identified, and care and treatment are regularly reviewed and updated. Appropriate referral pathways were in place to make sure that individual patient needs are addressed.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients told us that they were given enough to eat and drink, we observed patients receiving lunch and dinner. We noted that alternatives were found for patients who did not like the meal they had chosen.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. We reviewed patient records such as fluid balance charts which confirmed that patients had been given enough to drink.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We reviewed nine Malnutrition Universal Screening Tools (MUST). MUST is a five-step screening tool to identify adults, who are malnourished or are at risk of malnutrition. All the records we reviewed where comprehensive and up to date.

Staff told us that they had access to specialist support from staff such as dietitians and speech and language therapists for patients who needed it.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Information about people's care and treatment, and their outcomes, is routinely collected and monitored. The service participated in relevant national clinical audits. Accurate and up-to-date information about effectiveness was shared internally and externally and was understood by staff.

Outcomes for patients were generally positive, consistent and met expectations, such as national standards. Managers and staff used the results to improve patients' outcomes.

Improvement is checked and monitored. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. For example, the trust took part in the National Sepsis Quality audit to assesses the proportion of patients who undergo sepsis screening.

Managers used information from the audits to improve care and treatment. Managers shared and made sure staff understood information from the audits. Managers told us they shared and made sure staff understood information from the audits. Information gained from audits would be shared through staff meeting and group emails.

Competent Staff

The clinical educator supported the learning and development needs of staff. We spoke with two student nurses who told us they were able to complete all relevant tasks within their competencies.

Staff told us they were given time and had the opportunity to develop their skills and knowledge. For example, staff had enrolled onto training courses for trauma and the triage system.

Staff we spoke with confirmed that where relevant, staff are supported through the process of revalidation. There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff told us they had good working relationships with frailty teams, palliative care, physiotherapists and occupational therapists.

Medical care (including older people's care)

Where unexpected discharges, transfers and transitions occurred, processes were in place to ensure that people were not unduly at risk, including communicating people's specific, individual needs. Staff worked with other agencies when required to care for patients. Staff supported each other to provide good care. They had reliable links into services that maintained a rounded approach to caring for their patients.

Records we reviewed confirmed that patients had their care pathway reviewed by relevant consultants as appropriate.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on the Acute Medical unit, including weekends. Patients were reviewed by speciality consultants depending on the care pathway.

Staff could call for support from doctors and other disciplines, including mental health services pharmacy and diagnostic tests, 24 hours a day, seven days a week.

Is the service caring?

Inspected but not rated

Compassionate care

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

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.Patients said staff treated them well and with kindness.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring patients. Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Understanding and involvement of patients and those close to them.

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment. Staff made sure patients and those close to them understood their care and treatment. We observed staff talking with patients, families and carers in a way they could understand.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make informed decisions about their care. All patients we spoke with gave positive feedback about the service.

Medical care (including older people's care)

Is the service responsive?

Inspected but not rated

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities it served. It also worked with others in the wider system and local organisations to plan care.

The service had systems to help care for patients in need of additional support or specialist intervention. The service relieved pressure on other departments when they could treat patients in a day.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Two patients told us that they had been offered a selection of Halal foods while in the AMU. Menus available in the AMU and discharge lounge had clearly marked Halal, vegetarian, vegan and Kosher options.

Facilities and premises were appropriate for the services being delivered.

However, all the staff we spoke with told us there were challenges for the provision of care in the community, which impacted on the service's ability to discharge patients in a timely way. Staff gave us several examples of where a timely discharge had not been possible due to a lack of domically care packages being available or delays in patient transport services.

Patients we spoke with were positive about the care they received but told us that long waits following discharge were draining.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Staff could access emergency mental health support 24 hours a day seven days a week for patients with mental health problems.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Patients' relatives told us that staff went out of their way to ensure that patients had the help they needed so they could communicate with those caring for them.

The trust's internal Inpatient satisfaction score from across the trust, improved marginally in February 2022 to 92.9% compared to 92.6% in January 2022.

Medical care (including older people's care)

Access and flow

People could routinely access the service when they needed, however they did not always receive the right care promptly.

Managers and staff worked to make sure patients did not stay longer than they needed to. However, at the time of inspection, there was no enhanced care in AMU. Enhanced care provision means the service can offer single organ support for example a type of non-invasive ventilation (NIV) or breathing support. (BiPAP) above general ward level This meant that patients who were a direct referral into AMU by their GP for assessment could not always have their care and treatment needs met. These patients were discharged from AMU into the emergency department as a new attendance. This meant there was a risk of significant delays to diagnosis and treatment for patients.

There were four bed meetings each day. We observed two bed meetings and saw that there were clear messages about capacity within the hospital and the numbers of patients that needed to be admitted from the emergency department. There were consistent messages about when patients would be ready for discharge and effective communication between departments.

Managers and staff started planning each patient's discharge as early as possible. Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Managers told us they had carried out a lot of quality improvement work to try and improve flow through the AMU and discharge area, however this work was still ongoing at the time of the inspection. Staff we spoke with told us that new improvements were being brought online on a regular basis to improve the flow of patients through the AMU.

We observed four patients who had been discharged from the Accident and Emergency department and had been in the discharge lounge for over two hours. We were told if they deteriorated, they would be taken back to the emergency department and readmitted. Staff told us that delays in discharge were due to several factors, such as long waits for patient transport services or waits for discharge medications.

We received data from the trust that showed that performance relating to discharge summaries, which showed that only 55% had been completed on AMU. This did not meet the trust internal target of 90%. The clinical Effectiveness Overview Report, March 2022, identified that the AMU struggled to meet discharge compliance targets during weekdays. This meant that there was limited assurance that managers monitored the number of patients whose discharge was delayed and took appropriate action to prevent delays.

At the time of inspection, data indicated that one of the main reasons for patients being in hospital for more than 14 or 21 days was awaiting therapy decision to discharge; this was around 27% of all delays. An audit was carried out by the trust in March 2022 focused on therapy escalations, each patient was reviewed by a clinician using the Patient Electronic Notes System, the finding across the trust showed an error rate of approximately 80%. This meant that the trust was not always ensuring that patients were consistently discharged in a timely manner. Delayed discharges were also related to lack of suitable social care provision.

We noted that the Operations and Performance Monthly Report presented to board in March 2022, confirmed the establishment of a Patient Flow Collaborative with a focus on discharge planning to ensure commencement on day one of admission and to provide education and support to ward staff. In relation to transfer of care documentation, criteria to reside and discharge on specific pathways. In order to improve flow through the trust.

Medical care (including older people's care)

All staff we spoke reported delays associated with the completion of the revised Healthcare Needs Assessment (HNA). This document was completed by therapists prior to a patient being discharged and detailed the level of care they would need in a community setting. Staff told us the revised document took more time to complete which caused delays for patients

Is the service well-led?

Inspected but not rated

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 AMU and Discharge Lounge were part of the trust's medicine directorate. From early 2022 the trust had introduced a hospital leadership team for each of the hospitals in the trust to provide stronger operational site management as well as the directorate and specialty cross-trust management structures. The hospital was led by a medical director, nursing director and operational director.

On the AMU the ward manager had an open-door policy so that staff could speak to them and raise any concerns at any point. The ward manager was visible on the wards and supported staff when needed.

Staff commented that senior nurses and ward managers where visible and supportive.

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. There were 21 current risks on the risk register for the medical division. We saw that each risk had a risk manager and risk owner, there was a summary of controls in place, next review date and a series of actions to mitigate the risk.

The highest risks on the register were:

Delay in inpatient discharge due to lack of community capacity, resulting in extended patient stays and delays in the emergency department.

The demands on the emergency departments impacting on the division's ability to provide timely and effective care.

The service 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 culture of identifying, reporting and mitigating risks within both the AMU and the discharge lounges. We saw that managers were well-sighted on the main risks in relation to discharge planning, coordination timely clinical input and access to primary care support.

Medical care (including older people's care)

Senior leaders spoke about how the service had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements.

All staff received Central Alerting System (CAS) alerts via email from Public Health England. Lead nurses and matrons were responsible for reviewing alerts and disseminating to teams.

Areas for improvement

MUST

Royal Liverpool Hospital

- The trust must ensure that staff have the time they need to fully complete all discharge documentation appropriately and all ongoing work relating discharge summaries is completed in a timely manner.

SHOULD

Royal Liverpool Hospital

- The trust should ensure that all staff are compliant with mandatory training.