CareQuality Commission

NHS Southport and Ormskirk Hospital NHS Trust

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Last rated 15 Nov' 2016

Adult Accident & Emergency

You said	We listened	We did
Although there was a culture of reporting and learning from incidents, staff did not have a focused approach to reviewing patient deaths (mortality).		*All patients who die in the department who are not pre-hospital cardiac arrests are discussed at a local 'harm meeting' to make sure that all appropriate care was delivered. Findings are recorded and shared*
Mandatory and statutory training compliance was not meeting the Trust target of 90%		*A Clinical educator has established mandatory training study days for A&E and observation ward nursing staff. Staff are allocated to attend on a monthly basis. This has now resulted in month on month improvement in mandatory and statutory training which is actively monitored to ensure consistency*
There was no obvious signage to inform people that CCTV was in use within the areas		*Permanent signage is now in place within the A&E department.*
There was poor care whereby a patient experienced delays being monitored and receiving treatment for sepsis. Staff were not consistently using tools to help identify patients at risk of deterioration or identifying these risks themselves. National and local guidelines and care pathways were in place to support staff providing care, but the use of the pathways for managing sepsis was limited and some elements of sepsis care were worse than the regional average.		*A 'sepsis lead doctor' has been introduced on each shift with key responsibility for managing any patient with a diagnosis of sepsis* *Sepsis trolleys with necessary equipment rolled out within wards and A&E* *We have introduced a 'Deteriorating patient Clinical lead' and a 'Deteriorating patient hub' to support improvements in practice* *Monthly sepsis audits in place. Cascaded to team and shared in A&E harm meetings. Improvement plans in place to address areas required.*
Local systems were not in place to audit records of patients to ensure that they received appropriate care and that all relevant risk assessments had been consistently completed and recorded. Only a small number of patients were included in routine Trust wide monthly audits of clinical observations and early warning scores and these were showing omissions		*Additional funding agreed by Trust board to allow A&E to have appropriate and safe staffing levels at all times, these posts are actively being recruited into* *All patients have timely observations recorded whilst in the department (including those in the care of ambulance crews).* *Harm meetings to identify instances where observations have been omitted and lessons learned are shared at team meetings and department safety huddles.*
The department was not meeting the Department of Health target to admit, treat or discharge 95% patients within 4 hours. Re-attendance rates for patients were also worse than the national average.		*A Head of Patient flow has been recruited* *Daily Huddle introduced to raise awareness across the site of daily pressures and performance* *Trust awarded 'most improved performing Trust' by NHS Improvement (NHSI).* *Actions from The Emergency Care Improvement Programme (**ECIP**) report to be monitored monthly at A&E delivery subgroup meetings.*