Barking, Havering and Redbridge University Hospitals NHS Trust

Queen's Hospital

Inspection report

Rom Valley Way
Romford
RM7 0AG
Tel: 01708435000
www.bhrhospitals.nhs.uk

Date of inspection visit: 31 October 2023 and 1 November 2023
Date of publication: 22/12/2023

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at Queen's Hospital

Requires Improvement 

Barking, Havering and Redbridge University Hospitals NHS Trust is a large provider of acute services, serving a population of approximately 800,000 in outer North East London and Essex. The trust operates from two sites: Queen's Hospital and King George Hospital, with approximately 900 beds across both sites. The trust employs over 8000 permanent staff, sees over 300,000 attendees through their emergency departments and delivers over 7000 babies a year.

In the last year, Queen's Hospital emergency department saw 60,806 adults and 23,333 children.

Patients present to the emergency department either by walking into the reception area of the urgent treatment centre which is managed by another provider and is co-located on one level with the emergency department of Queen's Hospital or arriving by ambulance via a dedicated ambulance-only entrance directly into the emergency department. Patients arriving at the urgent treatment centre are assessed and directed to the trust's emergency department if required.

The emergency department has different areas where patients are treated depending on their needs, including a rapid assessment and first treatment area (RAFT), resuscitation (resus), majors, same day emergency care (SDEC) and the children's emergency department which is a separate unit with its own waiting area and bays within the department.

We last inspected the trust's emergency departments in November 2022 due to ongoing concerns regarding the urgent and emergency care pathway and patient safety. The emergency department at Queen's Hospital was rated overall inadequate. At this inspection our rating of Queen's Hospital emergency department improved. We rated it is as requires improvement overall.

Urgent and emergency services

Requires Improvement 

Our rating of this location improved. We rated it as requires improvement because:

- The two rooms in the children's emergency department which were being used as mental health rooms had no doors and no ensuite facilities which did not maintain the privacy and dignity of the patients. There were also potential ligature risks within the children's mental health rooms which meant that patients could not be left unsupervised.
- During our inspection we saw patient records left out on notes trolleys. Notes trolleys were not locked and some notes trolleys did not have a lock. We found notes of another patient in a patient folder and a patient's own medicines were found in a notes trolley.
- Not all patient records were consistent in the recording of risk assessments.
- Staff did not always follow processes to identify patients on time critical medicines.
- Piped air outlets were not always capped in line with recommendations of a national patient safety alert.
- Self-administration of medicines was managed by the patient. There was a policy for this and a risk assessment, however we did not see evidence of these being completed during our inspection.
- The layout of the children's emergency department meant that the resuscitation room was very close to the rest of the department which meant that everything in the room could be heard by others in the unit including a child's parents/relatives who did not have a designated room or area to wait while the child was being resuscitated. This would be very distressing to patients on the unit as well as the parents/relatives of the child.
- Not all mandatory training compliance levels met the trust target.

However:

- Staff assessed risks to patients and acted on them. The trust had improved the emergency care pathway within the service.
- 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. Staff worked well together for the benefit of patients and, supported them to make decisions about their care. Key services were available seven days a week.
- Although the department was still undertaking corridor care during busier times, the trust now had mitigations and strict criteria in place to protect the dignity and privacy of patients as far as possible which staff we spoke with were well aware of.
- Although there remained delays in ambulance handover times, the trust had implemented actions that had improved this.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, 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 had a good understanding of the challenges to the service. Staff understood the service's vision and values, and how to apply them in their work. They were focused on the needs of patients receiving care.

Urgent and emergency services

Is the service safe?

Requires Improvement 

Our rating of safe improved. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills however some compliance rates did not meet the trust target.

The service provided mandatory training in key skills to all staff. Mandatory training modules were a mixture of face to face and online training. At the time of our inspection mandatory training compliance levels were averaging 80% which was below the trust target of 90%. The lowest compliance levels for nursing and medical staff were paediatric basic life support which was 54.3% and adult immediate life support which was 54.2%, resuscitation level 4 adults at 48.6% and resuscitation level 4 paediatrics at 51.8%. These compliance levels were below the trust target of 90%. The trust told us that resuscitation training had been impacted post Covid due to the availability of trainers and course availability. However, the trust had a plan in place to ensure staff were booked on to the training in order to increase compliance.

Mandatory training was comprehensive and met the needs of patients and staff. Modules included but were not limited to: safeguarding adults and children, equality, diversity and human rights, health, safety and welfare, moving and handling, fire safety and resuscitation and infection, prevention and control. Other role specific training modules included but were not limited to: antimicrobial stewardship, autism awareness, dementia, blood transfusion, NEWS2, falls prevention and management, counter terrorism, sepsis, learning disability, and mental capacity act and deprivation of liberty safeguards.

Bank and agency staff also completed the hospital's mandatory training programme.

The service had also recently received an intake of international nurses and had developed bespoke training for the cohort to help them settle into the emergency department and understand processes and procedures within the department.

Staff told us they had protected time to complete their mandatory training. Practice development nurses were responsible for monitoring mandatory training completion. Reports were sent weekly by the central compliance team, and this was reviewed by the leadership teams for each area.

Medical staff mandatory training was monitored by service managers, and this was escalated to the clinical supervisors. If staff continued not to complete their training, this was then followed up by the clinical director.

The clinical group triumvirate reviewed the results of mandatory training compliance weekly and followed up with the individual staff groups.

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. However, some safeguarding training compliance rates were lower than the trust target.

Urgent and emergency services

Staff we spoke with were aware of their responsibilities in relation to safeguarding vulnerable adults and children and were able to define the triggers that would prompt them to obtain a safeguarding assessment for patients. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

As of October 2023, 100% of nursing and medical staff had completed safeguarding adults level 1, 93.5% of medical staff and 90.3% of nursing staff had completed level 2 safeguarding adults training which exceeded the trust target of 90%.

85.3% of medical staff had complete safeguarding adults level 3 which was below the trust target of 90% and 91.7% of nursing staffing had completed safeguarding adults level 3 training which exceeded the trust target of 90%.

97.7% of nursing and medical staffing had completed safeguarding children level 1 training which exceeded the trust target of 90%. Safeguarding children level 2 training compliance for nursing staff was 100% and 80% for medical staff. Safeguarding children level 3 training compliance for nursing staff was 81.1% for nursing staff and 82.1% for medical staff. This was below the trust target of 90%. Following the inspection, the trust told us that low compliance was mainly due to staff strikes, covid-19 and the availability of trainers. However, the trust submitted documentation showing that staff had been booked onto safeguarding training over the next 4 months to increase compliance.

Staff were knowledgeable about safeguarding processes. Staff in the children's emergency department told us they had a safeguarding flag system in place within patient records. They also had access to the child protection information sharing system (CP-IS). Staff used a screening tool to assess children and double-checked details using the child protection information system. Any concerns would be escalated to the liaison health visitor and safeguarding team.

We observed nurses assessing three patients in the children's emergency department and saw that a full set of observations were completed including a full social history and safeguarding screening questions. Records showed that where appropriate staff made safeguarding referrals to the local authority for adults and children presenting themselves at the department following incidents of alleged abuse or self-harm.

Between 1 November 2022 to 31 October 2023 the department had made 227 children's safeguarding referrals and 164 adult safeguarding referrals to the relevant local authority.

All attendances aged from 0 to 17 years of age were reviewed daily by the safeguarding team. The safeguarding team also went through all referrals, and they were discussed at the weekly psychosocial meetings which were held jointly with other agencies where outcomes and learning was shared. Attendees included local authorities, social workers, paediatric consultants, the mental health team, and staff who attended for learning purposes.

Staff had access to the trust's safeguarding policy and knew how to access the safeguarding team for advice and guidance when required. The ED also had a dedicated safeguarding nurse who was based in the department and staff told us the team were supportive in providing advice.

The trust had an off-site independent domestic violence advocate (IDVA) service that could be accessed by staff for patients and the trust was in the process of bringing the IDVA on-site. The service also had access to a drugs and alcohol liaison service.

Urgent and emergency services

The emergency department had a policy in place for the management, referral, and treatment of female genital mutilation (FGM). A multi-agency referral was completed to ensure support packages could be put in place for women and their families. The service also had access to the female genital mutilation information sharing (FGM-IS) system which is a national system that supports the early intervention and ongoing safeguarding of girls, under the age of 18, who have a family history of female genital mutilation (FGM).

Cleanliness, infection control and hygiene

The service managed 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.

We found all areas of the emergency department to be maintained to a high standard of cleanliness with areas tidy, clean and free from dust. We observed patient areas in the department were visibly clean and had suitable furnishings which were clean and well-maintained.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff followed infection control principles including the use of personal protective equipment (PPE).

We observed cleaning staff working throughout the day in all areas of the emergency department to maintain the cleanliness of the department. We also saw staff cleaning equipment throughout the day. Green 'I am clean' stickers were in use to indicate when equipment had last been cleaned. There was signage on cubicle doors where patients with infections required isolation.

We saw that there was easy access to personal protective equipment (PPE) such as masks, aprons and gloves. There was sufficient access to handwashing and drying facilities. We saw that most staff were 'bare below the elbow' and were using hand sanitisers when entering and exiting the department and patient bays. We also saw a porter working within the department demonstrating good infection control practices and washing their hands before and after transferring patients to cubicles.

The service generally performed well for cleanliness. The department undertook monthly hand hygiene and decontamination audits. In addition, the trust infection prevention and control (IPC) team undertook quarterly environmental audits. The decontamination audit assessed the department's cleanliness, clinical equipment cleaning including toileting aids. The hand hygiene audit assessed the compliance of hand hygiene against the 5 moments, bare below the elbow and hand hygiene technique.

The IPC environmental audit was an in-depth audit of the patient environment, the general environment, staff competence and knowledge, and the management of linen, sharps, waste, and isolation room.

Compliance results for the decontamination audit from April to October 2023 was 83%. Hand hygiene compliance levels from May 2023 to October 2023 was 79.5%. This was below the trust target of 90%.

The IPC environmental audit for the last two quarters were 90% and 81% respectively. We saw that the IPC team had an action plan in place which followed up on all areas of non-compliance. Actions included regular spot checks and teaching session.

The ED had a dedicated IPC link nurse to support staff in the department.

Urgent and emergency services

Environment and equipment

The design, maintenance and use of facilities, premises and equipment mostly kept people safe. However, the mental health assessment rooms in adult and children's ED did not have ensuite facilities. There were ligature risks within the mental health assessment rooms in children's ED which meant that patients could not be left without supervision.

The emergency department had different areas where patients were treated depending on their needs, including an urgent treatment centre (UTC) which was run by another provider, a rapid assessment and first treatment area (RAFT), resuscitation (resus), majors, same day emergency care (SDEC) and the children's emergency department which was a separate unit with its own waiting area and bays within the department.

Access from the main hospital entrance to the emergency department was by a corridor which passed radiology, a high dependency unit and intensive care. Patients walking into the emergency department having been streamed from the urgent treatment centre, were checked in at reception and directed to the rapid assessment and first treatment area (RAFT) of the department where they would be assessed by a clinician. Outside the RAFT area of ED, the passageway was joined by another corridor leading from the ambulance-only entrance.

All patient bays had a call bell next to the bed. Patients could reach call bells and staff responded quickly when called. However, not everyone we spoke with knew where their calls bells were.

There was one designated mental health assessment room without ensuite facilities. The service could provide a mattress for this room when patients stayed overnight. If a patient using the rooms presented a risk, nurses would inform security and ask them to stay close to the rooms. Staff reported a significant and sustained increase in the number of patients presenting with mental health conditions, rising to up to 12 patients at a time. Staff therefore also used other rooms for mental health patients and said they could remove most equipment from these rooms if needed.

Within the children's emergency department, the service could treat patients in designated rooms. The rooms were not specifically designed to minimise the risks presented by patients with mental health needs. If the patient presented a heightened risk, the service placed them in the mental health room within the main ED. There were no ensuite facilities available.

The two rooms used for paediatric mental health patients included ligature anchor points so patients could not be left in these areas without supervision, which impacted upon their privacy, particularly during long stays. The room used did not have a door, further impacting on patients' privacy.

The mental health assessment rooms were located centrally within the adult and children EDs, presenting safety management concerns for patients with challenging behaviours cared for in close proximity to other patients with significant physical health problems. Where there were no ensuite facilities, staff had to escort children and adult patients to use toilet facilities in other areas within the ED.

Assessment rooms were covered by CCTV, however there was no signage to make patients using the rooms aware of this.

Medicines rooms were locked to prevent unauthorised entry. Linen cupboards and storage rooms were appropriately stocked and tidy.

An emergency trolley was available in every area of the department. They were secured with a plastic snap lock, so it was clear if someone had accessed the resuscitation equipment. Trolleys were checked daily and weekly and a log was

signed to confirm checks had been made. Resuscitation trolley check sheets listed equipment which was ticked as checked and signed by the allocated staff member to confirm checks had been made. Consumables and equipment were appropriately stored and labelled. We checked various consumables such as fluids and found them to be in date and sealed.

Staff carried out daily safety checks of equipment. Each area of the emergency department had ‘safe to fly’ folders where checks of equipment, and fridge temperatures were recorded daily.

We saw evidence that equipment had been serviced and calibrated regularly. We checked various items of equipment such as defibrillators and blood pressure monitors and found they had been safety tested. Oxygen cylinders were stored securely and were in date.

We checked consumable equipment drawers and found that all items we sampled were in date and packaging was intact, indicating it was sterile and safe for use in patient care.

Waste management was handled appropriately, with different colour coding for general waste, and clinical waste. All clinical bins were seen to be operated with lids and were not overfilled. Waste management and removal including those for contaminated and hazardous waste was in line with national standards. We inspected sharps bins and found them to be correctly labelled and not filled above the maximum fill line.

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.

Patients presented to the department either by walking into the reception area of the urgent treatment centre (UTC) or arriving by ambulance via a dedicated ambulance-only entrance. The ambulance service telephoned the department to alert them of the arrival of a patient needing immediate treatment, so a team could be arranged to receive the patient immediately upon on arrival. All patients were triaged by a doctor and were streamed to different areas of the department based on risk. Triage is the process of determining the priority of patients’ treatments based on the severity of their condition.

Patients attending at the front door were streamed by a member of the UTC staff to the most appropriate area. Streaming involved taking a brief history and performing basic observations including calculation of early warning scores. Patients requiring to be seen in the ED were referred to the emergency department and were either escorted to the emergency department or directed to the corridor leading to the department.

Children who did not attend by ambulance were seen for an initial assessment by the staff and if they required emergency department treatment, were directed to the children’s emergency department where triage was undertaken by a nurse.

Patients brought with them documentation from the urgent treatment centre which indicated to the reception of the emergency department how long they had been waiting initially at the urgent treatment centres. The UTC and ED utilised different IT systems which meant that the ED did not have immediate visibility on delays for streaming. The UTC leads attended the three hourly 'pitstop' reviews and delays were discussed and communicated via this route.

Leaders told us that that they were in the process in the next week of having access to the same system as the UTC so that the transfer of the initial assessment information would be more robust and provide the teams with assurance that patients were arriving at the ED for their treatment.

When ambulances arrived at the department, the patient was registered onto the ED computer system and the crews waited with the patient for handover. Clinical handover was taken in an assessment cubicle and if no space was available, the patient was returned to the corridor with the ambulance service until a space became available within the department.

If after 45 mins there was still a wait, the ambulance service would leave the patient in the care of the nurses and healthcare assistants allocated to this area.

There were escalation processes for ambulance staff to use which included using the National Early Warning Score (NEWS2) tool and the modified versions for children and neonates. NEWS2 is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in patients and is a key element of patient safety and improving patient outcomes.

Patients with cancer were flagged on the service's computer system so staff were made aware of the need to isolate them.

Staff identified and quickly acted upon patients at risk of deterioration. The trust's deteriorating patient policy was up to date and during our inspection we observed staff responding quickly and effectively to a clinical emergency with a patient.

The department conducted monthly audits looking at compliance with NEWS2 scores. Between April 2023 and October 2023 compliance varied between 77% and 100%. We reviewed 20 records during the inspection and saw early warning scores had been completed for all patients. The children's emergency department used an age appropriate paediatric early warning score to assess deterioration and we saw that this had been completed for the patients that we observed who had been admitted to the children's emergency department during our inspection.

Vital signs were recorded electronically so that information could be accessed and monitored in real-time so any indication of patient deterioration could be responded to quickly.

Staff completed risk assessments for each patient on arrival, using a recognised tool such as the Rockwood clinical frailty scale, falls risks, and sepsis.

The trust stroke team were available 7 days a week, 24 hours a day and consisted of 2 senior doctors and 2 nurses. The team ensured that patients received timely scans and time critical treatments.

We observed a morning handover and saw that staff shared key information to keep patients safe when handing over their care to others. The meeting was clear, organised, and concise with the appropriate allocation based on skills of staff. Key messages were also disseminated to staff.

In addition to bed meetings to discuss capacity, staff told us that there were daily huddles throughout the day in each area of the ED to discuss any issues and surges. Staff also told us of debriefs following an incident in the ED.

Urgent and emergency services

Board rounds are a structured way to support the day-to-day running of the department and help the team manage patients safely and effectively. We saw that the primary board round took place in the middle of the rapid assessment and first treatment (RAFT) area with the multidisciplinary team which meant that patient information could be overheard by patients in the fit to sit area nearby.

The trust provided training records which showed that as of November 2023, 52.7% of nursing staff had completed level 3 adult immediate life support (ILS) training. Compliance for paediatric advanced life support level 3 was 63.2%. This was below the trust target of 90%. Compliance for nursing staff for level 4 paediatric advanced life support was 95.2% which was above the trust target of 90%.

For medical staff in the department, compliance for adult life support training was 74.2% which was below the trust target. Compliance for level 4 adult advanced life support training was 48.6% and level 4 paediatric advance life support training was 37.5%. This was below the trust target.

Following the inspection, the trust told us that low compliance was mainly due to staff strikes, covid-19 and the availability of trainers. However, the trust submitted documentation showing that staff had been booked onto safeguarding training over the next 4 months to increase compliance.

The department used a sepsis six care bundle which was designed to offer basic interventions within first hour. Patient notes were marked with a red sticker where sepsis was identified.

From May 2023 to October 2023 the trust reported 1452, 60-minute ambulance handover delays where a patient waited overed an hour from ambulance arrival at the ED until they are handed over to the emergency department staff. From the data provided, there had been a steady reduction of 60-minute ambulance handover delays from 529 in May 2023 to 69 in October 2023.

he leadership team recognised that the increase in mental health patients was one of the challenges the department faced. The department acknowledged that there was a risk around mental health patients bed capacity and mental health patients staying for an extended period. This had been recorded within the department's risk register with several actions in place including the appointment of an ED consultant lead for mental health and joint monthly meetings with the local mental health trust as well as daily escalation reports to mental health providers.

The department had conducted monthly audits looking at observations of mental health patients placed on enhanced observations. Results between January 2023 and October 2023 ranged from 70% to 97% completion.

The service had 24-hour access to psychiatric liaison team and specialist mental health support provided by a local NHS mental health trust. The trust did use security guards to support mental health patients in the department. Security guards had received the relevant training around restraint. Staff in the children's emergency department told us they had a good relationship with the children and adolescent mental health services (CAMHS) team. There were processes in place for CAMHS support out of hours.

The service completed risk assessments for patients who presented with mental health needs, however they did not detail how people's risks would be minimised. This was further complicated by three different recording systems in place for staff at the service which were a mixture of paper and electronic records.

Urgent and emergency services

If a patient left the unit before treatment and referrals were complete, and the patient presented a risk of harm to themselves or other people, the service would contact the police. Staff in the ED were aware of the new protocols coming into place regarding support with mental health patients – 'Right Care Right Place.'

There were significant waits out of hours, for patients to be assessed by approved mental health practitioners and section 12 approved doctors, particularly for children.

Staff reported significant waits for children and adults with behavioural social care needs, when placements broke down, and had a protocol to inform the chief nurse if a child was being accommodated in one of the adult assessment rooms. One child patient had recently waited in ED for 4 weeks.

Staff provided a parallel assessment when possible, and the psychiatric liaison team and psychiatrists were visible within the emergency department. They had fortnightly meetings to discuss patients who frequently attended the ED, and how they could best be supported.

Staff had protocols for administering rapid tranquilisation when necessary, encouraging de-escalation, and offering patients to take oral medicines if possible, prior to its use.

There was no current training from the psychiatric liaison team, but there were plans to introduce this in the future. There were no staff within the ED with substance misuse training however there was a drugs and alcohol liaison service which could be accessed. The teams could call on the disability team for support with patients with learning disabilities or autism. Managers spoke of plans for general nurses to undertake training in restraint.

Nurse staffing

On the days of our inspection, we saw that 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. However, the service did have a high vacancy rate for band 5 nurses. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The hospital used a safer staffing tool to determine staffing levels. Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift in accordance with national guidance. There was an information board in each area of the emergency department which accurately detailed the staffing levels for the day.

Leadership team huddles called pit stops took place throughout the day to discuss patient acuity and reallocation of staff to areas where there was more need. The leadership team told us they also were in close contact with a representative of the urgent treatment centre in order to understand demand.

We spoke with some bank and agency staff who confirmed that they had received an induction prior to working at the trust. Managers told us they used regular agency staff who were familiar with the service.

The service had enough nursing and support staff to keep patients safe. The number of paediatric trained nurses working within the department meant they were compliant with Facing the Future Standards for Children in emergency care settings. This meant the department was always staffed with two registered children's nurses.

The children's emergency department was always staffed with a minimum of two registered children's nurses. In the last 6 months, 13% of shifts were unfilled by a children's nurse. This included the summer period where attendances were

significantly reduced, and shifts were not required to be filled. Children's nurse staffing was monitored through the biweekly nurse staffing meeting which was supported by the ED staffing coordinator. At this meeting, rotas are reviewed and where gaps are identified, staff are moved cross site to ensure skill mix was maintained. The service also used bank and agency staff to fill shifts. All bank staff were registered children's nurses and agency staff were predominantly children's nurses. In addition, children's nurses could be moved from other areas such as the paediatric wards so support the children's emergency department.

There was a high vacancy rate of 38.2% for band 5 nurses as of August 2023. The trust had recently recruited a large cohort of international nurses and had plans in place with regards to recruitment to mitigate this risk. There had also been an agreement to substantiate the required ED establishment to match the ED safer nursing care tool. The trust were able to demonstrate that they would have a remaining 8 vacancies once all of the new starters were in post.

The ED was also working with the rest of the trust on a nursing retention strategy.

Medical staffing

On the day of our inspection, we saw that 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 trust told us that in the last 3 years, they had been able to improve medical recruitment in the emergency department which led to double the number of regular registrars and the implementation of a system to ensure a continuous influx of international medical graduates into the department.

The trust had a vacancy rate of 22% for medical staffing in the emergency department.

We were told that there were 4 ED consultants in the paediatric ED with further recruitment in place for an additional consultant. Paediatric consultants covered the department from 9am to 10pm Monday to Friday and 9am to 6pm at weekends. Outside of these hours, an ED adult consultant was available on call.

During our inspection we saw that there were enough consultants in each area of the adult ED. After 5pm we were told that the total number of consultants reduced to 3 to cover the department however, they were supported by a team of senior clinicians including HST (higher specialist training) specialist registrars, middle grade doctors and RCEM accredited emergency medicine advanced clinical practitioners.

Junior doctors told us that there were sufficient numbers of consultants on duty, and they could access support when needed.

Records

During our inspection we saw that some patient records were left unattended within the department and not all trolleys were locked or lockable. We also found that not all patient records were consistent in the recording of risk assessments.

We reviewed 20 patient records. Staff kept appropriate records of patients' care and treatment. However, during our inspection we saw some instances where patient records were being left unattended within the department. In addition, we found that not all notes trolleys were locked or lockable. This meant that there was a risk that patient notes could be accessed by unauthorised persons.

Urgent and emergency services

The trust currently used a mixture of paper and electronic patient records. This meant that it was not always easy to see if all documentation had been completed by looking at just a paper patient record. This was currently on the department's risk register and plans were in place to transfer over to a fully electronic system which was scheduled for implementation in 2025.

Patient notes were mostly comprehensive, and all staff could access them easily. However, we found that not all paper patient records were consistent in the recording of risk assessments such as falls, the hourly safety checklist, skin integrity assessment and bed rail assessments.

We also found a patient's own medicine within patient notes and a patient's notes in the wrong patient record folder. This was rectified immediately when we escalated this to the nurse in charge.

In addition, we saw that there was no opportunity for free text on nursing documentation within the body of the CAS card which was the form used to record initial observations when the patient arrived in the emergency department. The ED used the NHSI checklist to record care given as well as the free text on the narrative section of the patient's electronic record. The current documentation meant that there was more than one location in which the patient's nursing care was recorded. This would mean the next time information was recorded was within the 7 day booklet (where various risk assessments were recorded). This meant there would be a gap before additional information about the patient was documented.

Following the inspection, we were told that improvements to the documentation for the ED were being made utilising the risk assessments from the current 7 day booklet and incorporating the NHSI checklist for the first four hours of the patient journey. The mental health documentation would also be incorporated into new patient booklets to reduce the need for having two separate documents and provide a more holistic approach. This would mean there would be more opportunities for free text records. Additional training had also been implemented to support newly appointed nurses with completion of documentation.

The psychiatric liaison team recorded their interactions with patients on another electronic system which staff could not access however, there were plans to provide an interface by which the trust's staff could access these.

Matrons completed monthly audits of the 7 day booklets which documented completion of risk assessments, comfort rounds, hygiene needs, nutrition and Braden scoring for pressure ulcer risks. From April 2023 to September 2023, the completion of risk assessments ranged from 83.9% to 95.8%. Documenting of comfort rounds in the same period ranged from 89.8% to 96.4%. The documenting and completion of hygiene needs in the same period ranged from 93.2% to 100% and the recording of nutrition ranged from 89.8% and 100%.

Medicines

Although the service had systems and processes in place to record and administer medicines, staff did not always follow these to ensure that medicines were administered in a safe and timely manner.

Staff did not always follow systems and processes when safely prescribing, administering, recording and storing medicines. Staff did not always follow processes to identify patients on time critical medicines. The trust had implemented the use of stickers to highlight if patients were taking critical medicines. However, the triage notes were often left outside of their designated trays by the doctors, which meant nurses were not able to easily and readily locate them to administer these critical medicines. The administration records within one chart we reviewed, indicated that not all prescribed antibiotics and intravenous fluids were administered as intended. We were therefore not assured that time critical medicines were administered in a timely manner.

Self-administration of medicines was managed by the patient. There was a policy for this and a risk assessment, however we did not see evidence of these being completed during our inspection.

Staff told us they generally accessed online clinical references; however, out-of-date printed materials were also found.

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. Staff stored and managed all medicines and prescribing documents in line with the provider's policy. We saw the service had an up-to-date medicines management policy Microbiology protocols for the administration of antibiotics were available on the hospital intranet.

A pharmacist visited the department daily and checked prescription charts and controlled drug books. Staff told us they could contact the pharmacist at any time if they had any concerns regarding medicines patients were taking. There was an on-call pharmacist for out of hours requests and support.

Automated medicines cabinets were used to store medicines in each area. Staff were unclear how they would access these cupboards if they failed.

Piped air outlets were not always capped in line with recommendations of a national patient safety alert.

FP10 prescription pads were stored securely however, there was an excessive number of prescription pads in one area, therefore increasing the risk of misuse.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

Doctors used various sources to construct medicine history including information from patients, paramedics, and local health record. However, they did not have access to national health records and so constructing a medical history of patients in the ED from outside London may be more difficult.

Nursing staff were aware of the policies on the administration of controlled drugs (CDs). CDs were stored in line with required legislation and recorded in a controlled drugs logbook. We viewed the logbook where staff recorded when CDs had been used and stock was checked. Two members of staff checked the CD stock levels. We checked a sample of these and found them to be accurate and the medicine in date.

Room temperatures and fridge temperatures in medicines rooms were recorded daily. We checked the medicines fridge temperatures and ambient room temperature during our inspection and found them to be within expected range.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

From November 2022 to October 2023, there were 4412 incidents reported within the emergency department. Of these, 3561 incidents were categorised as 'no harm', 577 as 'low harm', 234 as 'near miss', 28 as 'moderate harm', 3 as 'severe' and 9 deaths.

Urgent and emergency services

The trust used an electronic incident reporting system to report incidents. Staff were aware of their responsibilities for reporting incidents and were able to explain how this was done. Staff told us they generally received feedback from their matron after reporting an incident.

Staff told us that learning was shared through a number of ways including via emails, during handovers, at daily huddles and bulletins from the safeguarding team. Staff also told us that learning from incidents and additional training was shared when staff met for keeping in touch days which were held twice yearly.

We viewed the minutes for monthly mortality and morbidity meetings which were held for the emergency department. The meetings provided an opportunity for serious incidents to be presented and discussed, and lessons to be learned. The minutes showed a good attendance by different levels of medical staff and discussions around incidents and learning. Minutes of the meetings were within teams and sent out in an email for those unable to attend.

The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff had a good knowledge of duty of candour and, senior staff were very clear about their responsibilities in relation to DoC.

Staff reported an increase in incidents of violence and aggression in the ED over the last year. Governance meetings were held monthly in the ED, during which staff presented cases of incidents in involving violence and aggression and missed opportunities. The service kept records relating to the restraint of patients and recorded this on the electronic records system. Security staff described a good relationship with the police, providing support when needed.

Is the service effective?

Good 

We did not inspect effective at our last inspection. We rated effective as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service delivered care in line with national clinical guidance. Staff had access to policies and procedures based on national guidance. Policies were available on the hospital intranet.

We reviewed a sample of hospital policies including policies for safeguarding adults, medicines management, infection prevention, anaphylaxis, acute asthma, trauma and the deteriorating patient which were all in date and appropriately referenced national guidance and best practice such as that recommended by the National Institute for Health and Care Excellence (NICE).

We saw established care pathways within the emergency department. We reviewed pathway folders for neck of femur, sepsis, non-invasive ventilation, and end of life care and found that they were in line with national and NICE guidelines.

Urgent and emergency services

Adherence to and understanding of NICE guidelines was embedded and evidenced through the use of audits to benchmark practice. The service was able to demonstrate that it participated in national clinical audits such as the society for acute medicine benchmarking audit, infection control in the emergency department audit, fractured neck of femur audit, and the falls and fragility fracture audit programme.

The service took part in royal college of emergency medicine (RCEM) national audits and as a trauma unit in north central east London trauma network, participated in the trauma audit and research network (TARN).

The service also monitored data such as infection control, records, medicines management, and equipment checks.

The service used evidence based 'care bundles'. A care bundle is a set of evidenced based interventions that, when used together, can improve patient outcomes. For example, we saw that staff used the sepsis 6 care bundle which consists of three treatments and three tests for the management of patients with presumed or actual sepsis.

Managers monitored and discussed results at monthly emergency department quality and safety meetings.

The children's emergency department had completed the royal college of paediatrics and child health (RCPCH) facing the future - standards for children and young people in emergency care settings audit. Of the 70 standards, 24 (36.4%) had been met, 26 (39.4%) had been partially met and 11 (16.7%) of the standards had not been met. Actions and mitigations were in place where standards were partially or had not yet been met.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. They regularly looked after patients subject to Section 2 and 136 of the Mental Health Act 1983 and were familiar with the Code of Practice. They ensured that the psychiatric liaison team undertook daily checks of patients while they waited for psychiatric treatment. At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

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. The service made adjustments for patients' religious, cultural and other needs.

There were appropriate processes in place to ensure patients' nutrition and hydration needs were met. Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

We saw that catering staff were made aware of patients' dietary requirements. Food menus catered for different patient groups including those with specific dietary requirements such as allergies and intolerances. There were also halal and kosher options as well as easier to chew, energy dense, healthier choice, gluten free, vegetarian, and vegan options.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff gave pain relief in line with individual needs and best practice. They assessed patients' pain using a standardised pain assessment tool to measure patients' pain. Patients were asked to describe their pain with a score of 0 (no pain) to

10 (severe pain) with corresponding smiley face symbols so patients could indicate how they were feeling if they were unable to speak. The face, legs, activity, cry and consolability (FLACC) scale tool was used to assess pain in children. Patients who used specific tools at home could also be used. The trust had a pain nurse specialist and dedicated pain team who could be contacted to support patients and staff. Patients told us they generally received pain relief soon after requesting it.

We saw from patient records we reviewed that staff prescribed, administered, and recorded pain relief accurately.

Patient outcomes

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

The service was regularly reviewing the effectiveness of care and treatment through local audit and national audit.

The service was regularly reviewing the effectiveness of sepsis management through local and national audit. We reviewed the department's sepsis screening audit which showed that in the last 6 months the trust had achieved the 90% standard for screening for sepsis and were mostly meeting the 90% standard for initiating treatment. Actions were in place where improvements were identified; for example, extra training and spot checks to ensure there were no delays of over 1 hour in receiving antibiotics, and ensuring records were fully completed both electronically and on paper.

The service participated in relevant national clinical audits such as RCEM audits. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time.

Actions from the audits were shared via the daily huddle and in lessons learnt on a monthly basis.

The audit cycle programme for the emergency department was being reviewed as part review of the clinical governance structure and process within the clinical group.

9.9% of attendances to the ED were unplanned reattendances within 7 days of a previous attendance. This was higher than the England average of 8.9%. In response to this, the trust had tasked a nurse to screen all records of patients who did not have a completed discharge checklist or who had left before being seen. The nurse contacted any patients of concern to ensure that they had access to services they required and provided advice about where to access help if needed.

The trust had recently undertaken a 'complex streaming' pilot in paediatric ED following data from the royal college of paediatrics and child health (RCPCH) that although children and young people should have an initial assessment within 15 minutes of arrival this is not being consistently met nationally. In response to this, the trust had implemented a 'complex streaming' pilot in the children's emergency department in place of a traditional triage to improve patient safety, experience, and performance.

'Complex streaming' was designed to complement the initial streaming which is run by the urgent treatment centre to identify how quickly a child or young person needs to be seen by a clinician and to ensure timely initiation of investigations. This included carrying out assessments by the 'complex streaming' nurse within 15 minutes of the child or young person's arrival in the children's ED which included a review of observations and identification of any initial investigations or treatments required and initiated before the patient is seen by a clinician.

Early data analysis from the pilots had shown that the time to triage was 4.1 minutes which showed that patients had had their initial assessment well below the standard of 15 minutes as a result of the improved streaming process. A standard operating procedure had been developed to ensure staff have a clear pathway to follow and the data would be presented at the trust's quality and safety meeting.

Following and audit of the learning disabilities checklist, to identify the needs of a patient with learning disabilities in the emergency department, it was found that the checklist was not suitable for use with children. In response to this, the trust had redesigned the checklist to be more child friendly and this was currently being piloted in the department.

The service undertook regular deteriorating patient audits and found that there was poor compliance in escalation and understanding of the steps that should be taken to escalate the patient. The trust had therefore put in place additional training to ensure the correct steps were taken and this was in the process of being re-audited.

Documentation audits had also led to additional training for staff in how to reposition patients and record this on ED specific paperwork which had led to a reduction of hospital acquired damage to heels.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. Rotas we viewed showed good range of skills and experience amongst medical and nursing staff.

New staff were given a full induction prior to starting in the ED and worked closely with the department's practice development nurses. The service had also implemented a bespoke training programme for a recent new cohort of international nurses to help support their transition into working in the emergency department.

There were clear pathways for nursing development and each nurse was provided with the nurse development pathway. Each nurse was allocated a team that had a band 7 nurse team leader. The band 7 nurses completed appraisals and worked with the practice development nursing team to identify training.

Managers supported nursing staff to develop through regular, constructive clinical supervision. Staff had two keeping in touch (KIT) days a year which were designed to provide supervision for staff, training and learning sessions. These were full days of training, with discussions on incidents, learning sessions, including a session on wellbeing. We saw examples of previous KIT day agendas which showed training on sickle cell, learning disabilities and autism, and safeguarding and the mental capacity act.

A training needs analysis was completed for each department annually which reflected the learning needs of the staff within the department.

Nurses had access to the Capital Nursing course and had the opportunity to attend courses twice a year.

All nurses had completed Level 1 and Level 2 RCN competencies for Emergency Departments 50% of registered nurses had completed their post-registration ED nursing course. Further nurses were being sent on courses in the second semester of the academic year.

Managers supported staff to develop through yearly, constructive appraisals of their work and staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills. Nurses we talked to spoke positively about the appraisal process. As of October 2023, the total appraisal rate was 68.8% which was mainly due to a high number of registered nurses that had been employed over the last month.

As of October 2023, appraisal rates for medical staff were 96.8%.

Medical staff had access to training programmes and leaders had worked to improve clinical supervision and study leave for staff to attain further qualifications, skills, and experience.

The department currently had 25 registrars with over half of them possessing full MRCEM (membership of the royal college of emergency medicine) qualifications.

New international medical graduates undertook two weeks of shadow periods (a week at each site) before starting their role. There were several initiatives in place to support medical staff such as regular meetings with the clinical lead, team building dinners, mentorship, a foundation fellow programme to help prepare senior house officers for core training and an emergency medicine academy programme to support the development of registrars allowing rotations around other specialities outside of the ED.

Nursing staff had received a basic level of training in mental health and the trust employed agency registered mental health nurses to support people with mental health needs. Staff were in the process of completing the Oliver McGowan training on working with people with learning disabilities or autism.

Registered general nurses within the EDs did not carry out any restraint techniques on patients. However, managers indicated that there were plans for them to have training in this area.

Managers spoke of work being undertaken to support nursing and medical staff wellbeing and improve morale, including extensive support for new staff from overseas.

Multidisciplinary working

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

We saw evidence of good multidisciplinary team (MDT) working within the emergency department. Handovers were well attended by the full multidisciplinary team.

Nursing staff said consultants were always available for advice and support and there were good working relationships between colleagues. We observed a good working relationship between ambulance staff and ED staff.

We observed multidisciplinary approaches to care planning for patients and families. Letters were sent to a patient's general practitioner (GP) to share outcomes and discharge information including any special requirement such as referrals or change of medications.

Patients received care by a multidisciplinary team. For example, records showed that patients received input from consultants, nursing, pharmacy, physiotherapy, and nurse specialists.

We saw physiotherapists liaising with nursing staff and saw the patient records had input from physiotherapists. The therapy service worked closely with community teams and the frailty team to help the discharge process and avoid admission to hospital.

Matrons we spoke with felt that their divisional colleagues were very supportive of the pressures the emergency department faced and recognised and shared the ownership of speciality patients where the decision to admit had been made in the department.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. We observed ED staff working together with ambulance staff and there were well established links with the frailty team, therapists, and primary care practitioners.

The leadership team told us they were in regular contact with the local mental health trust to help improve the care of patients detained in the ED under the Mental Health Act and reduce the time patients spent within the department.

The leadership team also told us that they would also liaise with the urgent treatment centre throughout the day to ensure patients were not waiting too long before being referred into the emergency department.

Seven-day services

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

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, 7 days a week.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support available.

Patients' health was assessed upon entering the emergency department and staff were able to provide additional information to support patients to live a healthier lifestyle. For example, the service had relevant information promoting healthy lifestyles and support including leaflets on smoking cessation. The service also had access to the drugs and alcohol liaison service to support patients.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained consent from patients for their care and treatment in line with legislation and guidance. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Urgent and emergency services

We observed staff obtaining consent and procedures being explained to patients. Staff we spoke with understood the importance of shared decision-making with patients. All patient records we reviewed demonstrated consent was sought and clearly recorded in the patients' notes. We saw examples of records where patients' mental health needs were recorded.

Staff were aware of the trust's Mental Capacity Act (MCA) policy and how this could be accessed.

Staff understood Gillick competence and Fraser guidelines and supported children who wished to make decisions about their treatment.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Compliance among medical and nursing staff was 81.1% and 80.3% respectively.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act (MHA), Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

The safeguarding team monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them.

The mental health team or doctors carried out mental capacity assessments. Some staff were trained in carrying out brief mental capacity assessments known as 'mini-mental state' assessments for patients who may have dementia. When trust staff provided treatment for patients who had been assessed under the MHA but were waiting for an available mental health bed, records did not always make it clear under what authority this was provided.

Staff reported largely complying with the section 136 timescales of 24 hours, sometimes extending these by an additional 12 hours. However, in cases where patients detained under section 136 were assessed by a doctor and found not to have a mental health condition for which they could be detained, staff reported a delay in patients being advised that they could leave, whilst they waited for an approved mental health professional (AMHP) to see the patient. Although they said that they would not stop a patient from leaving in this situation, they were not always letting patients know that whilst it was recommended, they were not obliged to wait for the AMHP before leaving.

Is the service caring?

Good ↑

Our rating of caring improved. We rated it as good.

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. We saw staff taking time to interact with patients and those close to them in a respectful and considerate way. Patients' individual preferences and needs were always reflected in how care was delivered. Feedback from patients about the care they had received from staff was consistently positive.

Urgent and emergency services

At our last inspection we were concerned that the privacy and the dignity of patients were not being maintained when patients were being cared for in the corridor. At this inspection the trust had put in mitigations and strict criteria to protect the dignity and privacy of patients as far as possible when they were being cared for in the corridor when the emergency department was at capacity. For example, each end of the corridor was closed off so it could not be used as a thoroughfare and only patients who were mobile were allocated to the area so that they could easily walk to the toilets which were located in the adjacent same day emergency care area.

During our inspection, the corridor was not always in use but during our first day of inspection we spoke to patients who were being cared for in the corridor. Patients we spoke with told us staff treated them well and with kindness and they did not have concerns about privacy. Patients' relatives were able to stay with them in the corridor and were given a chair and small table. However, not all staff were aware of the availability of privacy screens for use in the corridor should the patients require them.

All patients we spoke to praised the nursing staff and commented that they were 'kind, caring and lovely.'

Staff were focused on delivering patient centred care and respected the individual needs of each patient, showing understanding and a non-judgmental attitude when caring for patients. Staff described how they would support patients living with dementia with the support from the frailty team. We saw that in the children's emergency department, children were given a choice of toys and activities as a distraction while they were being treated.

The ED was supported by the palliative care team for patients receiving end of life care. Staff told us they tried to ensure patients were allocated a side room until they were admitted if capacity of the department allowed.

Staff we spoke with understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs. Patients we spoke with told us staff were 'friendly and helpful'.

Patient feedback from the trust's own quarterly patient survey based on the national urgent and emergency care CQC survey, showed an improvement in positive responses to questions such as whether patients felt they were treated with respect and dignity. This had improved from 75% in 2022 to 81% in 2023.

The NHS Friends and Family Test (FFT) is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. In the children's emergency department, we saw that as at October 2023, 91.3% of respondents recommended the service.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them. Staff described to us how they had supported patients who had additional needs. They told us they were also supported by the frailty team, the dementia specialist nurses, and the learning disabilities team to support patients with additional needs. There was a dedicated play specialist in the children's emergency department who provided support to children undergoing treatment.

Urgent and emergency services

Patients told us that nurses were very supportive, and they appreciated when staff introduced themselves to them and listened to them. Patient feedback from the trust's own quarterly patient survey based on the national urgent and emergency care CQC survey, showed an improvement in positive responses to questions such as whether the doctors and nursed listened to what the patient had to say. This had improved from 75% in 2022 to 80% in 2023.

A patient we spoke with said that they had been brought tea and biscuits and had appreciated this as they had been waiting for a long time before entering the emergency department without having had refreshments.

Patients also commented that the volunteers in the department were very helpful, would bring refreshments but also would listen to their concerns and spend time talking to them which helped a lot when they were waiting for the next stage of their treatment.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff involved patients in decisions about their care and treatment. Patients told us they felt comfortable asking doctors and nurses questions and felt involved in their treatment plans. Patients told us staff spent time explaining and were happy to repeat any details that they did not understand. Patients commented that treatment was 'very thorough' and they appreciated being able to see a doctor quickly and talk about next steps with them. However, not all patients felt they received updates about the next steps of their care and treatment in a timely manner.

Staff told us they had access to communication aids where required and the support of the specialist teams to help support patients with additional needs.

Patient feedback from the trust's own quarterly patient survey based on the national urgent and emergency care CQC survey, showed an improvement in positive responses to questions such as whether patients felt they were involved as much as they wanted to be in decision about their care and treatment. This had improved from 63% in 2022 to 72% in 2023.

Patients and families we spoke with were aware that they could give feedback by contacting the patient advice and liaison service or speaking with the patient experience facilitators who actively circulated around the department floor.

Is the service responsive?

Requires Improvement ↑

Our rating of responsive improved. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care. However, corridor care was still required due to the lack of space when the emergency department was at capacity.

Managers planned and organised services so they met the needs of the local population.

Urgent and emergency services

Facilities and premises were mostly appropriate for the services being delivered. The department had sufficient facilities to treat emergency patients. There was access to diagnostics 24 hours a day, 7 days a week.

However, there were frequently many additional patients waiting for long periods to be admitted to an inpatient ward. This meant that the department was often full and there were difficulties finding space for patients which resulted in the use of corridors.

Patients presented to the department either by walking into the reception area of the urgent treatment centre which was managed by another provider or arriving by ambulance via a dedicated ambulance-only entrance into the emergency department.

Patients requiring to be seen in the emergency department were then highlighted to the emergency department team and the patient was directed to the trust's emergency department. The children's emergency department which consisted of 9 bays, 2 resuscitation bays and its own waiting room, was located in the same footprint as the ED but separate from the main ED.

Patients were triaged in the rapid assessment and first treatment (RAFT) area once they had been registered onto the hospital patient electronic system unless the patient had to be brought directly to the 8 bay resuscitation area (resus). The RAFT area consisted of 5 assessment cubicles, 4 examination bays, 2 side rooms and 15 fit to sit spaces. Once triaged in RAFT, the patient would be moved to majors or same day emergency care (SDEC).

Majors consisted of 23 bays and 1 mental health assessment room and was the area where patients awaited a decision to admit to a ward in hospital. Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. The psychiatric liaison team were always available, and the learning disabilities team were available from Monday to Friday but were on call at weekends for urgent advice and support.

The hospital had a same day emergency care (SDEC) area which provided same day care for emergency patients who would otherwise be admitted to hospital. Under this care model, patients presenting at hospital with relevant conditions could be rapidly assessed, diagnosed, and treated without being admitted to a ward, and if clinically safe to do so, could then go home the same day their care was provided. We saw patients on the SDEC care pathway met the SDEC suitability criteria. Queen's Hospital had 9 beds and 16 seats with its own waiting room consisting of 10 chairs. Leaders told us that the SDEC was still not being used effectively due to the bedded area which meant patients could stay longer than intended. They told us there were plans to remove the bedded area in order to ensure the SDEC could be used for its intended purpose of providing same day care for patients without the need to admit to hospital.

The therapy service also supported the department 5 days a week and worked closely with the frailty team and community teams to ensure the right input and equipment was provided upon discharge for patients so that they did not need to be admitted to hospital. The trust also told us that they had introduced frailty specialists in the initial assessment of patients arriving to the ED to help identify the correct care pathway early.

There was a purpose-built discharge lounge managed by a nurse and health care assistants which was used by patients waiting for transportation following treatment and care in the emergency department. The discharge lounge helped to relieve the capacity issues in the ED and free up beds. The trust had found that there was reduced usage of the lounge at weekends and were working on improving discharges at weekends which would then increase the use of the discharge lounge.

Urgent and emergency services

The trust had recently launched their frailty virtual ward. Virtual wards provide a safe alternative to hospital for patients living with frailty through community-based acute health and care delivery while freeing up hospital beds for patients that need them most. The trust involved the ED team, frailty wards, the frailty team (frail and older people advice and liaison (FOPAL)) and the community therapy team with a focus on 'step downs' of patients from the ED and inpatient wards. There were also plans to expand virtual wards to other patient cohorts such as acute respiratory infection and children and young people.

Meeting people's individual needs

The service was inclusive but could not always take account of patients' individual needs and preferences due to the demand on the service. We also found that the layout of the paediatric ED meant that the resuscitation room was very close to the rest of the department which meant that everything in the room could be heard by others in the unit. Staff 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.

Patients with mental health problems often spent a long time in the department due to delays in on-going psychiatric treatment. A mental health room had been allocated and adapted to accommodate their needs. Risk assessments had been carried out to ensure they were safe for people at risk of suicide. Arrangements were made for registered mental health nurses to provide care, often on a one-to-one basis. However, due to a shortage of inpatient beds, some mental health patients had to spend several days in the ED before being moved to a suitable facility. This was on the ED's risk register.

The layout of the paediatric ED meant that the resuscitation room was very close to the rest of the department which meant that everything in the room could be heard by others in the unit including a child's parents or relatives who did not have a designated room or area to wait while the child was being resuscitated. This would be very distressing to patients on the unit as well as the parents and relatives of the child.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Stickers were also placed on patient notes so that their needs were easily identifiable by staff. Staff had received training in learning disabilities and in responding to the needs of people living with dementia. The trust safeguarding team had developed a learning disability strategy and dementia strategy with input from patients and carers.

The trust had a dementia and delirium care plan which identified the individual needs of the person and promoted person centred care. A blue butterfly symbol was also used to indicate to staff when a patient was living with dementia. An outline butterfly symbol was used for patients without a diagnosis of dementia but were showing signs of dementia and/or delirium. Patients were also given a blue wrist band as a visual aid that worked in conjunction with the blue butterfly symbol to prompt staff about the needs of the patient.

There were play specialists within the children's emergency department to support children when they were receiving treatment.

Information leaflets we saw on display were in English and staff told us that they were able to print out leaflets in other languages if necessary. There were also QR codes on leaflets so that patients could view them in other languages using their mobile phones.

Staff told us there was a 24-hour telephone translation service available for patients and carers and interpreters or signers could also be requested.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

In response to patient feedback where patients felt they did not always know what they were waiting for, the trust had designed large wall posters which explained the patient journey at each stage of the process when in the emergency department.

We saw during our inspection, speaking to staff and from viewing the minutes of the senior staff and consultant's meetings that care in the corridor was still taking place when the emergency department was at capacity. There were now strict criteria in place with regards to the types of patients who were cared for in the corridor and mitigations in place to ensure the privacy and dignity of patients could be maintained. For example, patients being cared for in the corridor needed to be ambulatory so that they could easily walk to the toilets in the adjacent same day emergency care area. In addition, patients living with dementia or with a learning disability were not placed in the corridor area. When in use, the ends of the corridor were closed off and a circulating healthcare assistant and nurse would be allocated to the area to monitor patients. A bed was kept free in the adjacent same day emergency care area so that if a patient required support with personal care or needed medical attention, they could be transferred immediately to the vacant bed and be cared for by staff while maintaining privacy and dignity. However, not all staff were aware of the availability of privacy screens.

Patients were given 'sleep well' packs with eye masks in response to feedback that the lighting in the corridor area was very bright. In addition, patients in the corridor were provided with bottled water as there was not always enough space to place jugs of water next to the patient as well as hand and face wipes due to the lack of handwash facilities in the area.

The main waiting area for the SDEC was small and when this was full, patients waited in a narrow waiting area which was quite cramped. A healthcare assistant was based in the waiting area to monitor patients' vital signs and alert nurses if there were any concerns.

There was a notice board within the emergency department with information about MH support available in the local area. Adult patients could be offered access to patient experience and learning disability trolleys, including sensory and stress relieving aids, and age-appropriate arts and crafts and DVDs. There was also a young person's self soothe box available for patients in paediatric ED.

Access and flow

People could access the service when they needed it. However, ED performance was below the national standards although it had improved since our last inspection.

There were systems in place to manage the flow of patients through the ED to discharge or admission to the hospital.

Staff could see on the IT system the length of time patients had been in the ED as well as an overview of bed availability and flow of patients coming into the ED. Capacity was discussed at two site meetings a day with staff in the department. We observed one site meeting however, we did not see representation from the ambulance service to update the team on activity in the area. We also did not observe discussion around community hospital capacity and discharge opportunities. Following the meeting we were told that these conversations do take place but not necessarily at every site meeting.

Urgent and emergency services

On the days of our inspection, the department was not as busy as when we inspected previously in 2022. Staff told us this was unusual and not reflective of how busy the service usually is, describing the ongoing challenges with access and flow.

Staff still expressed frustration at the challenges presented by the lack of capacity in the local health and social care system which led to patients staying longer in the ED than they needed to and also requiring the use of the corridor. In addition, staff spoke of the impact on nursing on busy days when ambulance staff left patients to be cared for by nurses after waiting 45 minutes in the ambulance arrival corridor.

Staff spoke of a significant and sustained increase in the number of patients with mental health issues presenting at the ED. Staff told us paediatric patients with mental health needs had to wait for long periods of time for psychiatric assessments, and for beds due to a lack of local provision for children and adolescents with mental health needs. Staff escalated long mental health waits within the ED to the trust's silver command meeting daily, and attended surge planning meetings to address bed capacity within north east London. If patients were well enough, and consented to do so, staff encouraged them to attend a local integrated crisis assessment hub at a nearby mental health hospital.

During our inspection we observed some patients being triaged within the 15-minute expected standard and some patients being triaged within 30 minutes. Staff we spoke to stated that it was a challenge to meet the 15-minute triage time especially when patients had been waiting a long time at the urgent treatment centre. The median time from arrival by ambulance in the ED to triage by the ED team was 14 minutes.

The median total time in ED in September 2023 was 4 hours and 2 minutes which was a slight improvement from the median time in August 2022 which was 5 hours and 39 minutes but higher than the England average of 2 hours and 58 minutes for the median average total time in ED for all patients.

53.8% of patients waited between 4 and 12 hours from the decision to admit until being admitted.

There was an increase in the number of the trust's patients waiting more than 12 hours from the decision to admit to admission from 567 in September 2022, to 625 in September 2023.

In October, trust performance for patients seen, treated if necessary, and either discharged or admitted, within four hours of arrival in the emergency department was 49.3%. This was a significant improvement with an 18.5% increase since February 2023. Performance at Queen's Hospital as of October 2023, was 48.7% for patients being seen within the 4-hour standard. This was a significant improvement from 38.4% in October 2022. However, this was below the national performance in October 2023 which was 55.9%.

The 4-hour performance for all types of activity in the ED was 66.9% in October 2023. This was lower than the national performance for all types of activity which was 70.2% in October 2023 and lower than the national performance target of 76%.

The trust had been one of the lowest performing emergency departments nationally however, the October 2023 data had moved the trust out of the lowest 25% of trusts nationally.

During October 2023 there were 322 patients referred to mental health services. 127 were at Queen's Hospital. The average length of stay in ED for a patient referred to mental health services was 22.5 hours.

Urgent and emergency services

Staff and leaders told us same day emergency care (SDEC) for patients although had helped with reducing admissions, was still not being used effectively as the bedded SDEC area meant patients were staying longer than the intended purpose of the SDEC. There were plans in place to reduce the bedded area to discourage long stays in the SDEC. The average length of stay in the SDEC was 8 hours.

Ambulance handovers were not in line with standards for an ambulance handover (clinical handover and offload). Data from the trust showed that in the last 12 months, 9% of ambulance handovers were completed within 15 minutes and 35% of ambulance handovers were completed within 30 mins.

Managers monitored waiting times and ED performance using a dashboard. Performance was discussed regularly by senior leaders at quality and safety meetings, senior leaders' meetings, and consultants' meetings.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

The service clearly displayed information about how to raise a concern in patient areas. Staff understood the policy on complaints and knew how to handle them. Staff could give examples of how they used patient feedback to improve daily practice.

The service had an up-to-date complaints policy which provided guidance on how to manage complaints.

Complaints were overseen by the patient advice and liaison service who worked with the department's managers to resolve and respond to complainants.

Any learnings from complaints were discussed with teams during team meetings as well as being displayed on 'you said, we did' departmental quality boards to help improve daily practice. Patients we spoke with were aware of how to make a complaint and told us they felt comfortable about speaking directly with staff if they wanted to complain.

The emergency department at Queen's Hospital generally received a low number of formal complaints. Data from the hospital showed that in the last 12 months, the service had received 78 complaints. Complaints were investigated, learning was identified, and the service apologised to patients when something went wrong. Staff were able to describe actions and improvements that had been put in place as part of learning from a complaint.

The main themes from the complaints were around management of medical care, communication and waiting times. We viewed the patient advice and liaison service (PALS) monthly complaints log which captured the learning implemented from the complaints received.

Patients and families could give feedback by contacting PALS or speaking with the patient experience facilitators who actively circulated around the department floor.

The service had implemented quarterly patient surveys based on the national urgent and emergency care CQC survey to monitor progress made against the trust's action plans from the national survey. 26% of patients responded to the survey which was an improvement from the 17% response rate of the national survey. Of the 33 questions that improved

in performance, 21 questions improved significantly by 5-15 %. There was an improvement in questions around waiting times, communication with staff and discharge support. Four questions declined in performance with none declining by 10% or more. The questions which declined were in relation to experiencing violence and aggression, support with medication and knowing who to contact regarding their condition upon leaving discharge.

Actions as a result of the survey included bringing in privacy and dignity screens for patients being cared for on the corridor, scheduled visits from the patient experience facilitators and patient advice and liaison service offers to support patient queries in real-time, ED passports outlining where patients are within the ED process, more volunteers to support patients and gather feedback, patient experience trolleys, a communication crib sheet for staff, enhanced communication training, and conflict resolution training during KIT (keeping in touch) days for staff.

Is the service well-led?

Good 

Our rating of well-led improved. We rated it as good.

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.

There had been a change in the leadership structure for ED since our last inspection. The ED and acute services now formed a care group together and site leadership roles had been introduced to help the day to day running of the emergency department.

There was now a clear management structure with defined lines of responsibility and accountability in the clinical group leadership team and the site leadership team.

Although the leadership team were still in its infancy, they demonstrated high levels of experience and capability to deliver sustainable care. They had a comprehensive understanding of challenges and had a good grasp of the priorities of the service. There were a number of workstreams and projects in place to address the challenges the ED faced.

There were still challenges related to the wider healthcare system however, leaders were able to describe joint working with other stakeholders such as ambulance services, the local mental health trust, and the north east London system partners.

Staff told us they were supported by their managers to develop their skills, access development opportunities, and take on more senior roles.

All staff spoke highly of their managers. They also commented on the friendliness and visibility of the senior leaders.

Staff told us that they were able to raise concerns as needed. Most staff knew about the freedom to speak up guardians and how to contact them should they need to raise a concern.

Both nursing and medical staff of all grades across the emergency department spoke of good teamwork.

Urgent and emergency services

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The leadership team told us that the focus of their vision was to improve staff and patient experience, deliver high quality effective care to the local population, ensuring this was in line with health inequalities. This vision was supported by staff we spoke with. To achieve this, were planning to work more collaboratively with stakeholders across the north east London integrated care system.

Leaders told us that the redesign plans for the ED included optimising patient flow and removing the need for care in the corridor. As part of the redesign, reviews of the environment were planned so that the appropriate working and rest conditions could be achieved to improve staff wellbeing.

In addition, leaders told us that there was a recent review of the ED nursing workforce and medical workforce which would inform the medical model required and improve financial sustainability.

Culture

Staff were focused on the needs of patients receiving care. Most staff felt respected and valued. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff we spoke with told us they enjoyed working in the emergency department despite the daily pressures they worked under. Staff told us there was a strong sense of teamwork among all staff who worked in the department, and this was what motivated them in their day-to-day work.

We observed a very positive, open and honest culture within the teams across the emergency department which was based on shared values. Staff consistently commented on the supportive and friendly teamworking environment and a focus on delivering patient-centred care. However, there was also a shared frustration that capacity problems within the hospital resulted in long delays for patients in the emergency department and the need to use corridors to care for patients.

Staff were knowledgeable about the duty of candour and knew about the trust's processes and procedures and could give examples of how they applied the duty of candour and the learning that was shared from an incident.

Consultants we spoke with told us there was a supportive culture and they felt able to approach the senior management team. Staff told us the senior management team were visible throughout the hospital and felt able to report concerns to their managers.

Most staff felt valued and respected and spoke of supportive colleagues and a strong sense of team. However, some staff felt that they did not always receive enough support after incidents occurred within ED. Staff were worried about the level of aggression displayed by some patients but commented that the security staff who were based in the ED were very supportive.

Staff told us there were opportunities for development at all levels and were well supported by the practice development team. Staff spoke well of the keeping in touch (KIT) multidisciplinary training days.

Urgent and emergency services

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Governance processes had improved since our last inspection and were effective in developing the service. Staff at all levels were clear about their roles and accountabilities.

Governance meetings were well attended, and minutes confirmed a good attendance by department staff. Quality and safety meetings were held monthly, and information discussed included the risk register, incidents, safeguarding complaints, compliments, audits, areas of good practice, education, training, and workforce. Minutes produced were comprehensive and shared with staff who were unable to attend.

There were also monthly senior staff meetings and consultant meetings where ED performance was discussed as well as suggestions around improvement to processes, task and finish group updates and updates around staffing and recruitment.

Key messages and updates were shared with staff at handovers and daily huddles although not all staff said they attended huddles, and the meetings were not minuted.

Staff told us they were clear about their roles and felt supported by their clinical leads and senior managers.

Operational and clinical audits were used to drive service improvement, and results from national audits were discussed at quality and safety meetings.

Departmental policies were available on the hospital intranet and supported by standard operating procedures and processes.

Mortality and morbidity reviews were well-established and were discussed monthly at a separate meeting. Lessons learned were clearly described and actions documented.

Leaders told us they were in daily contact with representatives at the urgent treatment centre to discuss operational challenges throughout the day. To further improve their work together, we saw that there were plans to put in place formalised joint governance arrangements with the provider that managed the urgent treatment centre. We were provided with a draft of the terms of reference for the meeting however at the time of inspection, the meetings had not yet begun.

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.

Senior leaders and managers of the service had a good understanding of risks to the service, and these were appropriately documented in risk management documentation with named leads and actions. Risks on the risk register were reviewed regularly and discussed at the quality and safety meetings. Each risk was given a rating, review date and a set of control measures.

The issues and risks which managers identified were in line with what we found on inspection and there was alignment between these, and the risks outlined on the risk register. For example, the use of electronic and paper records to record patient care, crowding and capacity, extended lengths of stay for patients with mental health needs.

Since our last inspection the service had worked hard to improve hospital flow and the trust had an action plan in place which focused on improving this. Risks were discussed at monthly quality and safety meetings.

The trust had set up an urgent and emergency care improvement board to provide structure to the improvement initiatives that were ongoing across the urgent and emergency care pathway to ensure oversight and governance of the initiatives. There were 4 themed work programmes within the programme which looked at ED process improvement, admission avoidance, length of stay and discharge and collaboration between the urgent treatment centre provider and the trust. Monthly meetings looked at opportunities to improve patient safety, experience, and performance across the urgent treatment centre and trust ED pathway. There was a corresponding improvement plan and action log which was monitored at each meeting. The national emergency care improvement support team (ECIST) and the national getting it right first time (GIRFT) team had recently visited the trust, and both had offered support for the further development of the ED improvement programme.

In preparation for upcoming winter pressures, senior leaders and consultants also met with the chief executive on weekly basis to discuss any issues and escalate any pressure points they were experiencing.

The trust also worked closely with the local mental health trust, and we were told that the CEO met frequently with the CEO of the local mental health trust to share information and discuss concerns.

The trust had a local emergency preparedness policy in the event of a major incident.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

Staff had access to patients' health records and the results of investigations and tests in a timely manner. The hospital used a mixture of paper records and an electronic system. This meant that it was not always easy to see if all documentation had been completed by looking at just a paper patient record. The trust had plans in place to transfer to a fully electronic system for implementation in 2025.

We observed staff logging off after using computers and staff reported that they had a sufficient number of computer stations.

Staff commented that the IT system was user friendly and showed us they could easily find policies on the hospital intranet and access various systems without issue.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services.

Patients' views and experiences were gathered and acted upon to shape and improve the service. Patient experience facilitators circulated the emergency department to collect feedback from patients. A patient representative had also recently been appointed and was involved in a task and finish group to ensure that the food offering in the ED met the nutritional needs of the patients including hot meal provision for patients including those not in a standard bed base.

The department worked with the learning disability and dementia patient and carers groups to develop the way care was delivered in the ED. For example, the emergency department have increased the number of cubicle spaces with walls and doors to provide a better environment for patients with learning disabilities and patients living with dementia.

The ED also worked with the trust's patient experience team to identify patients to attend a focus group which was planned to take place in the next two months. This group would help inform the development of the redesign of the ED and the pathways that will be taking place over the next two years.

The hospital did undertake a staff survey which asked questions around staff job, team, people in the organisation, managers, health, wellbeing and safety at work, personal development, and the organisation. Response rates for the ED staff survey in 2022 were at 19%. Actions following the survey included increased collaborative working between band 6 and 7 staff, disability training for all staff, reflective work for all staff, external mediation service to work with staff, KIT training days, and increased signposting to wellbeing support.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

There was a programme of improvement and innovation which was chaired by the chief operating officer. The programme covered aspects of emergency care and looked at whole hospital flow for emergency attendances to ensure patients who did not require to be admitted are directed to the correct service. This included the implementation of the frailty virtual ward and a single point of access advice line for patients that are frail to ensure that patients were directed to the correct service in the right location. Also in development was a hospital at home service for paediatric patients.

Staff we spoke with told us they had been involved in quality improvement projects. One project focused on reducing violence and aggression in the ED caused by patients becoming frustrated when not knowing where they were in their treatment pathway. Signage within the department was created to better inform patients what stage they were in their treatment pathway.

Another project included the reorganisation of the intravenous (IV) fluids room to provide an easy and effective way for the staff to promptly find what they needed. The sense of urgency behind this project was escalated during the observations related to the RAFTing process as staff were frequently looking for IV fluids in the wrong place or not correctly restocking the room. Improvements included colour coding labels to be able to identify different fluids quickly and arranging boxes to reduce manual handling for staff.

There was a strong focus on research which was led by an ED consultant in the department. The trust had also recently appointed a research nurse and 2 research clinical fellows and were involved in several studies such as but not limited to immediate coronary angiography after out of hospital cardiac arrest (ARREST), and lower limb fractures in children cohort study (CORE Kids).

Urgent and emergency services

Areas for improvement

Action the service 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.

MUSTS

Emergency department at Queen's Hospital

- The service must ensure patient records are kept securely in locked notes trolleys and that when patient records are in use, that they are not left unattended. (Regulation 17 Good governance)
- The service must ensure patient records consistently document risk assessments. (Regulation 17 Good governance)
- The service must improve the safety of the rooms used for paediatric mental health patients. (Regulation 12 Safe care and treatment)
- The service must ensure that staff follow policy to identify and document patients who are on time critical medicines. (Regulation 12 Safe care and treatment)
- The service must ensure compliance with best practice around the use of piped air and medical gases. (Regulation 12 Safe care and treatment)
- The service must ensure that mandatory training is regularly updated and plans to improve compliance are implemented. (Regulation 12 Safe care and treatment)

SHOULDS

Emergency department at Queen's Hospital

- The service should consider making improvements to the children’s emergency department’s mental health rooms to protect the dignity and privacy of patients.
- The service should ensure that patients who are self-administering their medications are clearly risk assessed and this is documented, and these patients are identifiable in the ED to staff.
- The service should ensure national standards of care such as triage, handover and admission standards are met in line with legislation.

Our inspection team

We carried out an unannounced inspection on the 31 October 2023 and 1 November 2023 using our comprehensive inspection methodology.

The inspection team comprised of a CQC inspector, a CQC regulatory coordinator and specialist advisors. The team were also supported by CQC specialists in the areas of medicines management and mental health care. During the inspection we spoke with 29 patients and 30 members of staff at all levels and different disciplines. We observed patient care and reviewed internal documents and 20 sets of patient records. The team also reviewed policies and records.

You can find 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

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
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 17 HSCA (RA) Regulations 2014 Good governance