King George Hospital

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out an unannounced focused inspection of the emergency department at King George's Hospital on 20 January 2020, in response to concerning information we had received in relation to care of patients in this department. At the time of our inspection the department was under adverse pressure.

We did not inspect any other core service or wards at this hospital, however we did visit the admissions areas to discuss patient flow from the emergency department. During this inspection we inspected using our focused inspection methodology. We did not cover all key lines of enquiry.

This was a focused inspection to review concerns relating to the emergency department. It took place between 12pm and 7pm on Monday 20 January 2020.

There were areas of poor practice where the trust needs to make improvements.

The trust must:

- Ensure that all clinical areas are kept clean and tidy at all times.
- Ensure that all staff are aware of safeguarding and chaperoning policies in respect of the care of children and vulnerable adults and ensure that these policies are followed.
- Ensure patients in the Fit2Sit area are adequately monitored and managed to be supported to stay safe.
- Ensure that all fire exits and fire fighting equipment are clearly marked and free from clutter.

In addition, the trust should:

- The trust should work with colleagues in the external provider operating the urgent care centre to improve the flow between the two services.
- The trust should ensure that all NEWS/PEWS charts are consistently completed.

Professor Ted Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Urgent and emergency services	Requires improvement 	We carried out an unannounced focused inspection of the emergency department in response to concerning information we had received in relation to care of patients in this department. At the time of our inspection the department was under adverse pressure. We did not inspect any other core service or wards at this hospital. During this inspection we inspected using our focused inspection methodology, focusing on the concerns we had. We did not cover all key lines of enquiry.

Summary of findings

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Services we looked at

Urgent and emergency services

Summary of this inspection

Background to King George Hospital

We carried out an unannounced focused inspection (staff did not know we were coming) of the emergency department at King George's Hospital in response to concerning information we had received in relation to care of patients in this department. At the time of our inspection the department was under adverse pressure.

We did not inspect any other core service or wards at this hospital, however we did visit the admissions areas to discuss patient flow from the emergency department. During this inspection we inspected using our focused inspection methodology. We did not cover all key lines of enquiry

We previously inspected the emergency department at King George's Hospital in November 2019. We rated it as Good. Following this inspection, we issued three Requirement Notices, and updated the ratings for safe, responsive, well led and overall in line with out ratings principles.

Our inspection team

The team that inspected the service comprised of two CQC inspectors, and two specialist professional advisors with expertise in urgent and emergency care. The inspection was overseen by Bernadette Hanney, Head of Hospital Inspection.

Information about King George Hospital

The emergency department (ED) at King George hospital is open 24 hours a day seven days a week. Between October 2018 and September 2019, the service saw 82,411 patients with serious and life-threatening emergencies and others with minor injuries.

The hospital did not take trauma or child patients arriving by ambulance. The department included a paediatric emergency department dealing with all walk-in emergency patients under the age of 18 years.

There was an urgent care centre (UCC) run by another provider that was open 24 hours a day, seven days a week. This service was not part of the inspection. It was inspected in March 2019 and rated good. A clinician from the UCC streamed (directed) walk-in patients into the urgent and emergency services on site. The UCC did not do blood tests or X-rays and patients requiring these were referred to ED.

The department had different clinical areas with restricted access. Patients were treated depending on their needs, including a resuscitation area for patients with immediate life-threatening illnesses and injuries. This area had three bays with equipment for intensive treatment and support, including one bay where children were treated with equipment specifically for paediatric patients. There was a 16 cubicle majors area where seriously ill patients were taken. Majors included one bay which could be used as a high dependency bay facing the nursing station and three

isolation rooms, two with doors and one with curtains. These bays could be adapted to accommodate patients presenting with mental health (MH) issues. Minors area had six 'see and treat' cubicles for patients with less serious needs. The department also had a six bed clinical observation ward. The ward was used for patients awaiting test results, requiring overnight observation or needing social services support for discharge. This was also used to reduce late discharges home of elderly patients. Paediatric ED had its own waiting area.

During the inspection, we visited the emergency department only. We spoke with 15 staff including

Summary of this inspection

registered nurses, health care assistants, reception staff, medical staff, and senior managers. We spoke with 10 patients and their relatives. During our inspection, we reviewed 12 sets of patient records.

Requires improvement

Urgent and emergency services

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement

Summary of findings

We did not inspect the whole core service. However, we rated safe, responsive and well-led as Requires Improvement. We found that:

- The environment in the department was not clean and tidy.
- We observed fire exits and access to fire fighting equipment being blocked by equipment in the corridors.
- Staff did not always complete regular checks on patients who were in out of sight areas, placing patients at risk.
- Patients vital signs were not consistently monitored, placing patients at risk of undetected deterioration.
- The waiting area in the paediatric ED was extremely busy, at busy times patients and their families would have to stand whilst waiting.
- We were not assured that locum medical staff had completed all appropriate mandatory training.
- There was poor flow out of the department.
- Patients accessing the service via self referral found the streaming system confusing. This led to delays to treatment and access to the right care at the right time.

However:

- Generally staff told us that they enjoyed working in the department.
- The service had suitable equipment which was easy to access and ready for use.
- All staff were aware of the location of emergency equipment.

Requires improvement

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

Our rating for safe went down. We rated safe as Requires Improvement because:

- The department was not clean and tidy.
- We observed fire exits and access to fire fighting equipment being blocked by equipment in the corridors.
- Oxygen was not always safely stored.
- Patients were not always routinely monitored. In particular, patients in the Fit2Sit areas were not observed directly by staff and intentionally rounding was not completed.
- The streaming system for "walk in" patients was not clear to patients, creating a risk of delays to initial treatment. In particular, patients who had been referred into the department were not always able to access care in timely manner.
- National Early Warning Score (NEWS) cards were used to assess for patient deterioration. However, these were not always consistently completed, placing patients at risk of harm.

However:

- Staff had access to sufficient and appropriate equipment to keep patients safe.

Safeguarding

Staff did not always follow best practice in relation to safeguarding and the trust's chaperoning policy.

- During our inspection, we raised concern regarding a member of medical staff in the paediatric ED who was observed by members of our inspection team not following best practice in relation to safeguarding and the trust's chaperoning policy during the examination of a paediatric patient.
- This incident demonstrated either a lack of knowledge of or regard for safeguarding and chaperoning policies and a lack of respect for patient dignity.
- Following the incident, we escalated it to the emergency department matron and to the trust's senior leadership.

During the inspection we were told that the doctor involved would be spoken to. This had not happened by the end of the inspection. However, we were provided with the staff member's training record which indicated their safeguarding training was up to date. We were told that there was no specific training around chaperoning but that all staff were required to read the chaperoning policy as part of their induction. Following inspection, the trust informed us the doctor involved was subsequently spoken to and had been placed on restricted duties whilst an investigation into the incident was undertaken.

Environment and equipment

The service had suitable equipment which was easy to access and ready for use.

- The department was not clean and tidy. Throughout the department, there was litter and dust on the floor. The walls in the department were not well maintained. This presented an infection control risk. This was particularly the case in the Fit2Sit area in majors, where there were crisp and sandwich packets on the floor in unused bays. Following our inspection, we were provided a cleaning schedule for the department, which indicated the frequency with which each area should be cleaned. In addition, the senior leadership provided assurance that a deep clean would be undertaken in response to our concerns.
- In several areas fire doors and fire escape routes were blocked by equipment being stored in corridors. In particular, wheelchairs were stored in the corridor beside the psychiatric observation room, which was signposted as a fire exit. Whilst there was space at the side of the corridor for the wheelchairs to be safely stored, this was not done, meaning there were wheelchairs across the corridor which would block a timely exit in the event of a fire. The doors to theatres were also obstructed by a trolley. In the corridor outside theatres, a linen trolley was blocking access to the fire extinguisher and hose reel throughout our inspection.
- The door to the Fit2Sit area in Majors was propped open with a litter bin. This door was marked "fire door, keep closed". This presented a risk to patients and staff.
- There was sufficient equipment such as adult, infant and paediatric pulse oximeters, blood pressure

machines, thermometers, oxygen and suction for the number of patients requiring these. Patients had access to call bells to call for staff if required. Defribullators were available throughout the department.

- Oxygen cylinders were not always safely secured. There were five oxygen cylinders stacked in a cupboard marked "dirty linen" in the ambulance entrance corridor. This presented a risk to patients and staff.
- Staff had access to sepsis toolkits. These are ready made boxes which include sepsis step by step guidance and all of the items required to deal with a suspected sepsis patient quickly, for example, medicines and fluids.
- Resuscitation equipment was available and fit for purpose. It was stored in appropriate trolleys which were sealed with a tamper evident tag. Safety checks were carried out daily.
- All staff both clinical and non-clinical were aware of the location of the emergency equipment. Its location and how to use it was included in the induction of all staff.

Assessing and responding to patient risk

Risks to patients were generally assessed in a timely manner. However, patients were not always safety monitored and managed so they were supported to stay safe.

- All patients arriving by ambulance were clinically assessed within fifteen minutes of arrival. Ambulance staff brought patients into the department and handed over to a member of medical staff. Handovers generally took place at the Rapid Assessment and First Treatment (RAFTing) desk, whilst the patients remained in the corridor with another member of ambulance staff.
- Self-transported patients arriving at the department entered through a streaming system provided by an external provider. These patients were assessed by streaming staff employed by the external provider and then referred into the the external provider's urgent treatment centre, or into the service. Those patients referred into the service would then be triaged a second time to determine whether they should be treated in the majors or minors department. Paediatric patients were sent straight to the paediatric ED following initial assessment by the external provider's streaming staff. As the streaming service was provided by an external provider, the trust were not able to directly influence whether patients underwent an initial assessment within 15 minutes in line with the standards set out by the Royal College of Emergency Medicine.
- Patients and relatives told us that they found this system frustrating and confusing. A flow chart of the the system was displayed on the wall but this information was not available in other languages. One patient we spoke with explained that they were partially sighted and, therefore, had not been able to read about the system on the wall.
- We spoke with two other patients, one paediatric and one adult, who explained that they had been referred to King George's ED from Queen's ED. They had been provided a letter to this effect and told to present it at reception. When they had done so, they had been told to go to the back of the queue for the external provider's streaming system. We raised this with the trust who told us that the reception staff who had told them this were incorrect and that the patients should have been redirected to the trust's own reception desks, in adult and children's ED. They told us that they would speak to the external provider about this. Nonetheless, this highlighted the confusion that the system caused for patients.
- In addition, the streaming system impacted on the length of time that patients spent without treatment or pain relief, as patients were required to wait first for assessment by the external provider and then for triage and treatment by the trust.
- Within the adult ED, patients were triaged by both nursing and medical staff. Patients who were directed into the service by the streaming staff from the external provider waited in the main reception area before being called through for triage. Children who were directed into the service were called through to the children's ED waiting area to await triage.
- The children's ED waiting area was extremely crowded. In addition, prior to entering this area, children were required to wait in the main waiting area with adult patients. This meant that children were required to wait alongside adult patients for prolonged periods.
- There was a Fit2Sit area within the department, where patients who were assessed as fit to sit prior to treatment or admission into the hospital were directed

to wait. Patients in this area were not visible to staff at the nurses' station or working in the ED unless staff entered the area. At our last inspection, in October 2019, we highlighted the lack of oversight of this area to senior staff. Following the last inspection, senior staff introduced a system for a member of nursing staff to check on these patients every 15 minutes, signing a checklist to indicate they had done so. As a result of this assurance, we stated in our last report, published in January 2020 that the provider should continue to ensure oversight of this area.

- At this inspection, it was apparent that this was not being done. We observed that staff did not visit the area every 15 minutes. Further, seven patients that we spoke to in the area informed us that they had not seen any members of staff for over an hour. Staff we spoke with told us that when they were assigned to do so, they did not have time to check on the patients in the Fit2Sit area every 15 minutes as they were frequently required to help with other tasks within the department. They said that it was the practice for staff to sign the checklist retrospectively, to indicate they had checked the area when they had not done so. During our inspection, we escalated this to the senior leadership team.
- Further, we were concerned that even were the checks completed appropriately, this would not be sufficient to keep patients safe. If a patient were to deteriorate between 15 minute checks, other patients would have to be relied on to call for help and would have to leave the area in order to do so. The checklist was kept near the entrance to the Fit2Sit area, meaning that it could be signed without viewing all of the patients.
- Responsibility for checking the area was assigned to one nurse per shift. This nurse was employed as a "surge nurse" and was also required to provide additional assistance to colleagues elsewhere in the department. This increased the likelihood that the nurse would miss the fifteen minute checks. In addition, in the event of an incident, there was only this nurse available to deal with this situation.
- In response to raising these concerns, the trust made the following immediate changes: The staffing numbers assigned to the Fit2Sit area had been increased with immediate effect to ensure there was a registered nurse and health care assistant (HCA) available 24 hours per day seven days per week. The trust's volunteer team agreed to provide "mystery shoppers" to all of the waiting areas for an initial period of one month. All patients would be given a contact card which the nurse checking the waiting area would be required to sign every 15 minutes when they check them. This was to be trialled for one week and then any amendments made to the content before being embedded. To provide further random audits of completion, the corporate nursing team planned to complete a weekly audit of the CCTV footage in that area to ensure there was consistency with the staff completing the form, the patient card being completed and the CCTV footage.
- As part of their induction all reception staff within the department had received training on 'red flag' presenting complaints and the deteriorating patient. Red flags are signs and symptoms that indicate the possible or probable presence of serious medical conditions that can cause irreversible disability or untimely death unless managed promptly. However, the reception staff to which all self-referring patients presented were not employed by the trust but by the external provider for the urgent treatment centre. Therefore, the trust did not have oversight of their training. Following our inspection in October 2019, and to ensure better oversight of patients waiting in this area, the trust had introduced a system whereby a healthcare assistant sat in the main waiting area observing patients who were awaiting screening by the external provider or triage by the service's own staff. Senior staff in the service told us that funding had not yet been approved for this post and that, therefore, this was an additional cost to the department.
- The majority of staff we spoke with had received training in managing emergencies appropriate to their role. All staff we spoke with knew how to raise the alarm and seek urgent help in an emergency situation.
- Once they were admitted to the department, patients received a comprehensive assessment in line with clinical pathways and protocols. Patients were assessed using a combined form which contained a medical admission and nursing admission template. This included sections for clinical observations (national early warning score), Glasgow coma scale and details of past medical history, complaint history and a section for

treatment plans. These were completed by the nurse and doctors attending the patient and clearly described the assessment process, treatment given and planned, and the outcome of any investigations.

- The National Early Warning Score (NEWS) was used to identify deteriorating patients in accordance with National Institute of Health and Care Excellence (NICE) Clinical Guidance (CG50): "Acutely Ill Adults in Hospital: Recognising and Responding to Deterioration" (2007). The Paediatric Early Warning Score (PEWS) was used to assess and identify deterioration in paediatric patients. We looked at 10 NEWS/PEWS charts. Some charts were inconsistently completed and the documentation indicated that NEWS/PEWS scores were not being completed at regular intervals.
- NEWS is a point system implemented to standardise the approach to detecting deterioration in patients' clinical condition. On the charts reviewed, clinical observations were repeated in line with the previous score and escalated when scores were elevated. Compliance with escalation of NEWS was audited in the ED and was at 85% with an action plan to support improvement.
- Information was available to help staff identify patients who may become septic. Sepsis is a serious complication of an infection.
- As identified at our last inspection, staff did not have access to mandatory training on mental health issues, care of paediatric patients or palliative care. However, they did have access to mental health liaison service 24 hours a day, seven days a week. Staff knew how to make an urgent referral and patients were seen promptly. There were end of life care champions in the department who provided advice and bespoke training sessions for staff.

Nursing staffing

There were enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and and to provide the right care.

- The emergency department used a combination of the baseline emergency staffing tool and the National Institute of Health and Care Excellence (NICE) emergency department staffing recommendations, to ensure the department was staffed appropriately. This outlines how many registered nurses they needed to safely staff the department. The tools looked at the acuity of patients and how many were in the department at certain times of the day. As a result, the department had changed some shifts to provide a safe amount of staff at the busiest times of the day.
- At all times throughout our inspection, we found the skill mix of staff to be suitable for the needs of the emergency department, with actual staffing levels meeting the planned levels. Senior staff had oversight of the staffing within the department and moved staff around to ensure all areas were safe and they were able to manage surges in demand.
- Nursing staff told us that whilst the department was usually staffed to the planned staffing level, they felt that, due to the complexity and number of patients presenting at the department, additional nursing staff were needed.
- In spite of this, nursing staff generally spoke positively about working in the service.
- The department had both bank staff and agency staff who were used regularly. All the bank and agency staff we spoke to had completed an induction and were familiar with the department. These staff were able to cover some of the short notice issues such as sickness and likely increased demand.
- There were not sufficient registered paediatric nurses to cover every shift. To address this a number of staff had undertaken competencies to provide a safe environment when caring for children with advice sought for the paediatric wards when necessary. Review of the rotas showed there was always at least one nurse who had received paediatric immediate life support training on duty.

Medical staffing

There were enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care.

- There was a consultant present in the department for 18 hours a day, seven days a week, with a registrar (ST4) available 24 hours a day.
- We saw consultants working clinically in the department. They led the treatment of the sickest

patients, advised more junior doctors and ensured a structured clinical handover of patient's treatment when shifts changed. Handovers between different teams of doctors was well-structured and detailed. We observed early senior involvement in the treatment of patients throughout our inspection.

- Junior doctors spoke positively about working in the emergency department. They told us that the consultants were supportive and always accessible.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We did not inspect against this key question.

Are urgent and emergency services caring?

Good

We did not inspect against this key question.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Our rating for responsive stayed the same. We rated responsive as Requires Improvement because:

- Access to services was not always timely.
- There was poor flow out of the service.
- The department performed poorly against the national target for patients to be assessed within four hours.

However:

- Clinical managers monitored flow 24 hours and had a clear oversight of issues impacted on flow. They worked to alleviate these, but said they were not always supported to do so by colleagues in the wider hospital.

Access and flow

Patients could access the service when they needed to, although this was not always timely.

- Between 14 December and 10 January, 52.2% of patients were assessed within four hours against a national target for 95%. Whilst the majority of trusts in England haven fallen below the target, this service was performing significantly worse than the national average.
- There were systems in place to manage the flow of patients through the ED to discharge or admission to the hospital. The operations control room and clinical site team could see on the IT system the length of time patients had been in the ED, who had been referred and required admission. The system allowed them to have an overview of bed availability and the flow of patients coming into the ED. This was all discussed at regular bed meetings throughout the day and plans made. The general manager worked closely with the nurse in charge of the department to facilitate communication to the operations team. We saw evidence of this during our inspection. The general manager would be in the department trying to improve flow during busy times.
- The clinical site team provided 24 hour a day cover, seven days a week. They had an oversight of acute and emergency flow, along with ensuring capacity was maintained.
- Staff told us that there were often periods of overcrowding, when ambulance crews cannot offload the patient into the major's area. However, ambulance crews who we spoke with told us that the offloading process was quicker at this hospital than some others they visited.
- The service had a full capacity protocol (FCP) implemented. A full capacity protocol was recommended by the Royal College of Emergency Medicine. It was used to balance the risk to patients when EDs are overcrowded and there is no available space in which to assess patients. The FCP stated that specific wards have to care for an extra patient until a bed becomes available elsewhere, to free up capacity within the ED, so ambulances were able to safely 'offload' and handover the patient. During the

inspection, we saw the corridor area was in use for short periods of time. While they were in this area, patients were seen treated and cared for appropriately and moved to a cubicle in a timely manner.

Are urgent and emergency services well-led?

Requires improvement

Our rating for well-led went down. We rated well-led Requires Improvement because:

- Following the last inspection, the leadership team provided assurances that the Fit2Sit area would be monitored every fifteen minutes. During this inspection, we saw evidence that this was not being done and, further, a member of staff told us they were being encouraged to sign a checklist to indicate that they had done so when they had not.
- The audits of the Fit2Sit checklist nevertheless indicated a decline in completion. However, there had been no actions taken to address this decline.
- In spite of efforts to address them, there continued to be a disconnect between the service and the external provider operating the urgent care centre and with the wider hospital teams.

However:

- Staff generally described the local leadership as approachable and supportive.
- The service had managers at most levels with the right skills and abilities to run a service providing high-quality sustainable care.

Leadership

The service had managers at most levels with the right skills and abilities to run a service providing high-quality sustainable care. However, the department did not have a clinical lead at the time of inspection.

- There was a triumvirate leadership team consisting of a matron, a clinical lead and an operations manager for the service. However, at the time of inspection, there was no appointed clinical lead for the department. The previous clinical lead had resigned a few weeks before inspection and a replacement had not been appointed. There was no designated interim clinical lead.
- Throughout our inspection local leadership were present in the unit. Staff told us that they were generally approachable and supportive.
- At the inspection in October 2019, the senior leadership within the urgent and emergency care division told us that they did not always feel supported by colleagues in the wider trust. In particular, they were concerned that colleagues in other departments did not take responsibility for assisting with easing the pressure on the ED by accepting patients in a timely manner, or sending decision-making staff to visit patients in the ED. Further, they told us that on some occasions, staff from other specialties referred patients back into the ED in order to free up space in their own departments. During this inspection, we spoke to two patients who had been referred back into the department from other specialties. Staff told us that since the last inspection, there had been little improvement in the relationship with other specialities.

Vision and strategy for this service

Whilst the service subscribed to the trust's overall vision and values, there was no vision or strategy for the service itself.

- The service did not have a formulated vision or strategy for the department. None of the senior staff we spoke with could articulate a strategy for the service in view of a growing population and increasing demands. Senior leaders told us their aim was for the service was meet the demand of the population and to improve performance.
- Staff told us the same winter pressure plan had been in place for years and had not been adjusted, despite increasing workload for the department. However, after the inspection the trust told us that they do review capacity and demand for the winter period across divisions on a yearly basis, and festive period planning was also in place.
- There were escalation plans within the service. We had sight of the service's escalation policies. Staff told us that there were significant issues in relation to patient flow which led to crowding. Patients were experiencing

unacceptable waits. Whilst staff in the department followed the escalation policy, staff told us that actions taken by other departments in line with the policy did not prove effective at restoring flow. The lack of effective actions resulted in handover delays, overcrowding and poor patient experience.

Governance, risk management and quality measurement

The service had a systematic approach to continually monitor the quality of its services. However, systems for identifying risks, planning to elimate or reduce them were not embedded or effective

- Staff were aware of how to escalate concerns to the senior management in the department and said they felt confident to do so.
- Monthly ED consultants meetings took place to discuss updates, workflows or staffing.
- There were daily meetings to discuss incidents which fed into a weekly meeting. The weekly clinical governance meeting took place to discuss serious incidents and other departmental issues. At this meeting the team looked for any trends from incidents in the department.
- The department held joint governance meetings with the local mental health trust, to discuss governance issues relating to the care of mental health patients and collaborative working between the two services.
- During our inspection, we raised a concern regarding the signing of the checklist to indicate that 15 minute welfare checks had been carried out on the patients in the Fit2Sit area when this was not the case. The member of staff assigned to the area informed us that they were under pressure by the senior leadership to sign to say they had completed the checks when they had not done so. When we escalated this to the senior leadership, we were told that this would be investigated.
- We were told that the completion of the checklist was audited on a monthly basis and were provided with the results of the audits, which indicated completion rates of 92% in October, 86% in November and 81% in December 2019. Whilst these were high completion rates, this indicates a downwards trend in completion since the introduction of the checklist in response to concerns raised by the CQC at inspection in October 2019. In addition, we were provided with a copy of the checklist from the day of our inspection, which was signed to indicate that the area had been visited every 15 minutes throughout the day. This contradicted what we observed during our inspection and what were told by patients and a member of staff.

Culture within the service

Staff and managers across the service promoted a positive culture that supported and valued one and other.

- Staff told us that the service was a positive place to work. Some nursing staff told us, however, that there were not always enough staff to provide sufficiently timely care to the number of patients attending the service.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that all clinical areas are kept clean and tidy at all times.
- The trust must ensure that all staff are aware of safeguarding and chaperoning policies in respect of the care of children and vulnerable adults and ensure that these policies are followed.
- The trust must ensure patients in the Fit2Sit area are adequately monitored and managed to be supported to stay safe.
- The trust must ensure that all fire exits and fire fighting equipment are clearly marked and free from clutter.

Action the provider SHOULD take to improve

- The trust should work with colleagues in the external provider operating the urgent care centre to improve the flow between the two services.
- The trust should ensure that all NEWS/PEWS charts are consistently completed.

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 The Fit2Sit area and not being overseen by clinical staff. A member of clinical staff was supposed to visit the waiting area every 15 minutes to carry out a visual assessment of all patients. Staff signed a log to indicate this had taken place. However, we observed that staff were not visiting the area every 15 minutes. Further, staff told us this was difficult to achieve, especially during busy times and that the log was not always accurate. We were not assured that processes in place were effective to detect deteriorating patients in the waiting area.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment During our inspection there was an incident which indicated that not all staff were following, or were aware of the trust's safeguarding and chaperoning policies.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment During our inspection, the department was not clean and tidy. Further access to fire exits and fire equipment was blocked.