Queen's 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 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 Queen's Hospital on 20 January 2019, 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 inspect the whole core service and 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 the paediatric emergency department is adequately staffed with registered children's nurses
- Continue to ensure patients in the Majors B waiting area are adequately monitored and managed to be supported to stay safe.

In addition, the trust should:

- The trust should appoint a clinical lead for the service.
- The trust should review the pathways for patients accessing the ED.
- The trust should improve oversight of actual time to triage of patients arriving in the department thourgh the streaming service.
- The trust should continue working to improve A&E four hour target performance.
- The trust should continue working to reduce ambulance handover times.
- The trust should continue working to improve the flow of patients out of the ED.

Professor Edward 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. We rated safe, responsive and well-led as requires improvement.

Summary of findings

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Services we looked at
Urgent and emergency services

Summary of this inspection

Background to Queen's Hospital

We carried out an unannounced focused inspection of the emergency department at Queen'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 and did not cover all key lines of enquiry.

We previously inspected the emergency department at Queen's Hospital in October 2019. We rated it as requires improvement overall. Following this inspection, we issued two requirement notices.

Our inspection team

The team that inspected the service comprised of an CQC inspector, a national professional advisor with expertise in urgent and emergency care, an emergency department consultant and an emergency department matron specialist advisors. The inspection was overseen by Bernadette Hanney, Head of Hospital Inspection.

Information about Queen's Hospital

The Emergency Department (ED) at Queen's Hospital provides services 24-hours per day, seven days per week service. It is a neurotrauma centre. There are approximately 200,000 attendances each year. Of those attendances approximately 50,000 were children under the age of 16.

There was an urgent treatment centre (UTC) run by another provider that was open 24 hours a day, seven days a week. This service was not part of the inspection.

The ED consists of a Majors A treatment area consisting of 24 bays, a Majors B treatment area with six cubicles and a seated area for patients with lower acuity, a Rapid Assessment and First Treatment (RAFTing) area with eight cubicles and a seated area, assessment/treatment rooms and a resuscitation room with eight bays, including one for trauma patients and two for paediatric patients.

The department has a paediatric area with nine bays.

During the inspection, we visited the emergency department only. We spoke with 13 staff including registered nurses, medical staff, and senior managers. We spoke with 10 patients and relatives. During our inspection, we reviewed ten sets of patient records.

Detailed findings from this inspection

Requires improvement

Urgent and emergency services

Safe	Requires improvement
Responsive	Requires improvement
Well-led	Requires improvement

Summary of findings

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

- The paediatric department was not always sufficiently staffed with registered children's nurses.
- We were not assured by the processes in place to assess and respond to patients deteriorating in the majors B waiting area.
- 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.
- The service did not have clear oversight of the actual time to triage of patients arriving in the department through the streaming service.
- The national A&E four-hour target performance was consistently worse than the England average.
- Ambulance handover times with number of black breaches were worse than the national average (a black breach occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff).
- There was poor flow of patients out of the department to other areas of the hospital. Some patients spent more than 12 hours in A&E before admission to a ward.
- There was no clinical lead for the department.
- Cooperation with other specialities was not always effective.
- There was no vision or strategy for the service.

However:

- The environment in the department was clean and tidy.
- The service had suitable equipment which was easy to access and ready for use.
- Full capacity protocol and escalation tools were in place.

Requires improvement

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

We rated safe as Requires Improvement. We found that:

- The paediatric department was not always sufficiently staffed with registered children's nurses.
- Patients were not always assessed in a timely manner or monitored and managed so they were supported to stay safe.
- The service did not have full oversight over actual time to triage of patients arriving at the department.

However:

- The environment in the department was clean and tidy. Staff had suitable equipment, which was easy to access and ready to use.

Environment and equipment

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

- The department looked clean and was kept tidy. Corridors and rooms were well lit and uncluttered. Cupboards we opened were organised and stocked.
- The service was divided into five areas based around a central reception desk, which was staffed at all times. These were the resuscitation area, for patients who had been admitted via ambulance requiring resuscitation or trauma care; Rapid Assessment and First Treatment (RAFTing), where all other patients who attended via ambulance were initially assessed; Majors A, for patients who were admitted with more acute conditions or injuries; Majors B, for patients with lower acuity; and a paediatric emergency department.
- There were nine bays in the resuscitation area, including a trauma bay, one paediatric bay and a bay which could be used alternatively for adults or children. There was immediate access to the resuscitation area from the ambulance entrance.
- The RAFTting area had eight chairs, for patients considered "fit to sit" as well as eight trolley bays and two assessment rooms. There was a central desk for medical staff in the area, meaning that all patients entering the service were seen immediately by a member of the medical team, in addition there was a nurses' station opposite the medical desk, which allowed the nurse in charge a full view of the area.
- Majors A had 24 bed bays based around a central nurses' station. In addition, there was a psychiatric assessment room. The bay nearest to the nurses' station, which had walls around it, as opposed to curtains was used for patients requiring isolation. In addition, it could be used when available for patients living with dementia, learning disabilities or mental ill health who required a bed.
- Majors B had five cubicles and a seating area for patients deemed fit to sit, as well as a central nurse station.
- The paediatric emergency department was appropriately configured and equipped for children. It had nine trolley bays.
- There was sufficient equipment such as adult, infant and paediatric pulse oximeters (to monitor oxygen saturation), 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.
- 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 diagnose and treat suspected sepsis 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

Patients were not always assessed in a timely manner and waiting patients were not always monitored and managed so they were supported to stay safe.

- Patients presented to the department either via ambulance or through the on-site urgent treatment centre (UTC), which was managed by a separate independent provider.

Requires improvement

Urgent and emergency services

- Staff at the UTC saw all walk-in patients initially and directed them to the hospital's emergency department if appropriate, where they would be triaged. Triage is the process of determining the priority of patients' treatments based on the severity of their condition. This meant patients arriving in the department could have already spent time waiting at the UTC, therefore creating a situation where patients might have a prolonged wait for appropriate treatment.
- Standards set by the Royal College of Emergency Medicine states that an initial clinical assessment or triage should take place for all patients within 15 minutes of their arrival. However, waiting times to be assessed in the UTC were not recorded by the trust. This meant patients registering at the ED could have already waited significantly longer. As the streaming service was provided by an external provider, the trust were not able to measure whether patients underwent the initial assessment within 15 minutes. During inspection, we spoke with three patients who waited 30 to 40 minutes at the UTC and another 10 to 30 minutes at Majors B for triage.
- Triage nurses assessed all patients using safe and working triage system, which was aligned to a nationally recognised triage system, assigning a clinical priority to patients, based on presenting signs and symptoms.
- All ambulance patients were taken directly to the Rapid Assessment and First Treatment (RAFTing) area for handover and triage. Between 8am to 10pm, the handover would always be taken by an emergengy medicine consultant or registrar. The doctor assessed the patient's condition on arrival, ordered any tests, and categorised the patient by severity of presenting complaint, dictating the priority order of seeing the patient in the department.
- The median time from ambulance arrival to initial assessment was similar to or worse than the England median for 10 out of the 12 months from December 2018 to November 2019. February and April 2019 were the only months in the 12-month period when trust performance was better than the England average.
- Where a patient required resuscitation, the ambulance service telephoned the department to alert them of the arrival of a patient needing immediate treatment. The ambulance crew would bring the patient straight into the resuscitation area where a team would be waiting for them.
- The waiting area in Majors B, for patients awaiting triage, transfer to one of the cubicles or the fit to sit area, was not very spacious and became crowded during busier times. Patients also waited in the adjacent corridor due to lack of space, separated by a door and out of sight. The waiting area could be observed through a window by the Majors B receptionist. After the last inspection, the service introduced a policy for a member of clinical staff to physically 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.
- We were not ensured the processes in place to assess and respond to deteriorating patients in that waiting area were adequate. During inspection, we did not observe a member of clinical staff checking patients in the Majors B waiting area despite spending about half an hour there. The log sheet of the day that was later provided by the trust, however showed a member of staff signing the list during that period. Several members of medical and nursing staff told us about their concerns regarding this waiting area; that it was difficult to assess all patients especially during busy times, patients had serious medical conditions and about a third would need admission. However, we were not aware of any incidents in regard to this.
- In response to raising these concerns, the trust made the following immediate changes: The staffing numbers within the waiting rooms 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. In the UTC waiting room there will be one HCA and one HCA in the paediatric waiting room. 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.

- 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 using nationally recognised tools such as National Early Warning Scores (NEWS), 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 ten NEWS/PEWS charts and saw that they were completed correctly and regularly. NEWS is a points system implemented to standardise the approach to detecting deterioration in patients' clinical conditions. On the charts reviewed, clinical observations were repeated in line with the previous score and escalated for medical review when scores were elevated.
- Information was available to help staff identify patients who may become septic. Sepsis is a serious complication of an infection. There were sepsis risk assessment tools and a sepsis action plan pre-printed in all patient notes. Staff we spoke with were aware of the sepsis action plan. We saw the records of 10 patients in the department who had a completed sepsis assessment. During inspection, we reviewed the records of a patient treated in the department showing that diagnostic and initial treatment was completed within one hour of identification of sepsis. This was in line with the NICE guideline (NG51) Sepsis: recognition, diagnosis and early management. Sepsis toolkits were available to help staff diagnose and treat sepsis.
- All staff we spoke with knew how to raise the alarm and seek urgent help in an emergency situation.

Nursing staffing

The paediatric department was not always sufficiently staffed with registered children's nurses. However, adult service had enough nursing and support staff with the right skills and training to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

- There were not sufficient registered children's nurses to cover shifts in the paediatric department. Every emergency department treating children must be staffed with at least two registered children's nurses, as per national guidance set out in the Royal College of Paediatrics and Child Care: Facing the Future: Standards for Children in Emergency Care Settings.
- As highlighted at the last inspection, we found that the paediatric emergency department was not always staffed with at least two registered children's nurses. We saw rotas for the previous three months and found that in November 2019, 15 shifts were planned with only one paediatric nurse, 10 shifts in December 2019 and 11 shifts in January 2020. Staff told us that up to 60% of shifts only had one paediatric nurse on duty. To mitigate this, an adult nurse with completed paediatric competencies would cover the rota gap. The department had introduced a rotation programme for adult nurses to the the paediatric ED to gain competencies. However, there was a risk that when the paediatric trained nurse was busy, or occupied with a patient, other paediatric patients would not be treated by a nurse with the full relevant skill set.
- There was a shortage of paediatric nurses at the trust. The total funded establishment for the paediatric department across both sites was 44.74 whole time equivalent (WTE), which included nurses, nursery nurses and assistants. At the time of inspection, there was a vacancy of 10.63, of which 5 post had been recruited to. The remaining posts were out to advert. The department had made progress on nursing recruitment in 2019. As of 19 January, 23.26 vacancies existed for registered nurses at AFC band 5. With additional recruitment in January, this number would be reduced to 7 WTE in February. Recruitment was to continue to ensure full establishment by April 2020.
- In response to these concerns raised, the trust reviewed the competency document in place for adult nurses caring for children and children's nurses. The trust planned to deliver a revised competency framework reflecting the Royal College of Nursing (RCN)

Competency Framework for Emergency Nursing (2017). The trust's paediatric senior nursing team would lead this work to ensure robust implementation and assessment of practitioners. In addition the trust planned to develop a career map for children's emergency nursing to provide wider direction and workforce development. The initiation of the competency framework in revised format would commence in the first week of February 2020, the initial assessments to be completed within 30 days with an expectation that any outstanding issues would be completed within 90 days.

- During inspection, we found the skill mix of staff to be suitable for the needs of the adult emergency department, with adequate staffing 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. Cross-site bed meetings took place at least twice a day to also discuss and resolve any staffing issues.
- The emergency department used a combination of a crowd capacity tool and escalation tool to ensure the department was staffed appropriately. The tools looked at the acuity of patients and how many were in the department at certain times of the day. Guidelines and pathways were in place to direct staff during busy times and higher staffing demands.
- The department had both bank staff and agency staff who were used regularly. All bank and agency staff we spoke with 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.

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 24 hours a day, seven days a week, supported by junior doctors with different levels of experience.
- The department saw around 50,000 children a year and there were two consultants with sub-specialist training in paediatric emergency medicine. A third consultant post had been recently recruited to.
- 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. 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.
- Locum staff were used regularly to fill gaps in rotas and ensure safe medical staffing levels. There was a clear induction process in place.

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

(for example, to feedback?)

Requires improvement

We rated responsive as Requires Improvement. We found that:

- The A&E four-hour target performance was worse than the national average
- Ambulance handover times with number of black breaches was above national average (a black breach occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff).
- 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.
- There was poor flow out of the department. Some patients spent more than 12 hours in the emergency department before admission to a ward.

However:

- The service had made arrangements for times of higher demands and full capacity protocol and escalation tools were in place.

Access and flow

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

Requires improvement

Urgent and emergency services

- Patients attending the ED independently were initially assessed by a clinician from the co-located urgent treatment centre (UTC), which was not part of the trust. A streaming nurse assessed patients and depending on the presentation, patients were sent to the GP at the UTC, to the paediatric ED (for children under 16 years old) or to the adult ED. (Streaming is the assessment and decision by a clinician where patients can receive the most appropriate care and directing them to it).
- Any child or adult considered by the streaming clinician to be very unwell was referred directly to the paediatric ED or majors with registration being done later. This meant the sickest patients went through the system without delay. Remaining patients who required ED treatment waited for assessment by a triage nurse. Senior staff told us that if the waiting area became increasingly busy with many patients waiting to be triaged, they would deploy an additional triage nurse to improve patient flow and reduce waiting times.
- Patients sent to the ED had to walk from the UTC to the appropriate department. Patients could have difficulty finding the correct area and found the streaming process confusing. This could potentially lead to delayed care and treatment. During this inspection, we came across three parents with children asking us for directions to the paediatric ED.
- Patients arriving by an ambulance were triaged in the separate Rapid Assessment and First Treatment (RAFTing) area once they had been registered onto the hospital patient electronic system, unless the patient had to be brought directly to the resuscitation room. It had been reported that there were often periods of overcrowding, when ambulance crews could not handover the patient. During these periods, the corridor was used as extra capacity, where ambulance crews would wait with their patients. During the inspection, we saw the corridor area was in use for short periods of time. We spoke with ambulance staff during our inspection and they told us that this ED was often very busy and waiting times could be long. The service worked with the ambulance service and clinical commissioning group (CCG) to improve ambulance handover times.
- A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. Data from November 2019 showed that 17.5% of ambulances remained at the hospital for more than 60 minutes. This was worse than the national average of 8.9% and worse than the trust’s performance in November 2018 (10.4%).
- The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department. The trust did not meet the standard and performed worse than the England average. In December 2019, 67.6% of patients spent less than four hours in the ED; the national average was 76.7%. Less than half (44.6%) of patients spent less than four hours in A&E Majors during the same month, the national average was 68.6%. The trust performance was worse than national average throughout 2019.
- Median times from arrival at the emergency department to treatment at the trust was reported as 119 minutes in December 2019. This was worse than December 2018 (94 minutes).
- In December 2019, 12 patients waited more than 12 hours from the decision to admit until being admitted.
- There were systems to manage the flow of patients through the ED to discharge or admission to the hospital. The team could see on the IT system the length of time patients had been in the ED. 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 along with staffing numbers.
- The clinical leadership told us delays to admission, transfer or discharge was caused by poor flow throughout (and out of) the hospital as a whole, especially during winter months, as well as the significant numbers of patients arriving at the department. There was also poor flow within other specialties of the hospital as well as a lack of available care in the community for patients to be discharged to.
- A full capacity protocol (FCP) was 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 had to care for an

extra patient until a bed became available elsewhere, to free up capacity within the ED, so ambulances were able to safely handover patients. The service used a Crowding and Capacity Tool (CCT) and Escalation Trigger Tool (ETT) to support the use of the FCP.

Are urgent and emergency services well-led?

Requires improvement

We rated well-led as Requires Improvement. We found that:

- There was no clinical lead for the department.
- There was no service-level vision or strategy for the emergency department.
- Cooperation with other specialities was not always effective

However:

- Most staff felt supported by local leadership

Leadership

Most 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. However, the department did not have a clinical lead at the time of inspection.

- In general, staff spoke highly of local leaders within the service. They described them as approachable and supportive. They said they recognised the difficulties facing staff and were working to address them.
- 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.
- During our inspection we noticed senior staff were visible in the department. They were aware of the issues in the department and were proactive in attempting to address them.
- Most staff told us that they felt supported by the leadership within the service, who they said advocated on their behalf. They said, however, that they did not always feel that the service was supported by the trust-wide senior leadership team.

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.

Governance, risk management and quality measurement

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.

- There was an effective governance system in place in the service. Senior leaders were aware of the issues faced by the service and were aware when incidents occurred.
- There were monthly quality and safety meetings to discuss fixed agenda items, such as risks, incidents, audits or feedback. The director of nursing of the UTC attended these meetings.
- 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.

Culture within the service

Staff and managers across the service promoted a positive culture that supported and valued one and other. However, relationships across specialties did not always promote effective working.

- Most staff were positive about working within the service and praised the teamwork. Staff felt there was good supervision and support from senior member of staff.
- However, staff told us that consultants did not have admission rights and doctors of other specialities did not always review or accept referred patients in a timely manner.
- Staff told us other specialties within the hospital were reluctant to engage with the service and saw it as a "holding area" for patients. They said that they had raised this as a concern frequently with the local and divisional leadership and that, whilst there were pockets of good practice, for example in the care of the elderly team, there had been little improvement in the working relationship with other specialties. In addition, they told us that they had raised concerns about the lack of appropriate community care with local commissioners and were working with them to identify key areas of need.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure the paediatric emergency department is adequately staffed with registered children's nurses in line with national guidance.
- The trust must continue to ensure patients in the Majors B waiting area are adequately monitored and managed to be supported to stay safe.

Action the provider SHOULD take to improve

- The trust should appoint a clinical lead for the service.
- The trust should review the pathways for patients accessing the ED.
- The trust should improve oversight of actual time to triage of patients arriving in the department thourgh the streaming service.
- The trust should continue working to improve A&E four hour target performance.
- The trust should continue working to reduce ambulance handover times.
- The trust should continue working to improve the flow of patients out of the ED.

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 18 HSCA (RA) Regulations 2014 Staffing The paediatric ED was not always fully staffed with registered children's nurses. During inspection, we found that the paediatric emergency department was not always staffed with at least two registered children's nurses. Every emergency department treating children must be staffed with at least two registered children's nurses, as per Royal College of Paediatrics and Child Care: Facing the Future: Standards for children in emergency care settings There was a risk that when the paediatric trained nurse was busy, or occupied with a patient, other paediatric patients would not be treated by a nurse with the full relevant skill set.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The waiting area of Majors B was crowded and not overseen by clinical staff. Due to lack of space, patients could be waiting in the adjacent corridor, which was obscured by the door to the waiting room. About 30% of Majors B patients are admitted to the hospital, meaning patients seen in Majors B can have significant health problems. 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,

This section is primarily information for the provider

Requirement notices

staff told us this was difficult to achieve, especially during busy times. We were not assured that processes in place were effective to detect deteriorating patients in the waiting area.

Patients in the the waiting area could deteriorate unnoticed.