King's College Hospital NHS Foundation Trust

King's College Hospital

Inspection report

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Date of inspection visit: 26 July 2021
Date of publication: 30/09/2021

Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at King's College Hospital

Requires Improvement 

The Emergency Department (ED) at King's College Hospital is a Major Emergency Centre for the south east. It is a major trauma centre, hyper acute stroke unit, cardiac arrhythmia and cardiac arrest centre. It also fulfils its obligations as a type 1 emergency department for the local population.

The ED is open 24 hours a day, seven days a week and sees patients with serious and life-threatening emergencies. There is a separate paediatric emergency department dealing with all attendances under the age of 18 years. Patients present to the department either by walking into the ED reception area or arrive by ambulance via a dedicated ambulance-only entrance.

It is a busy department with almost 122,000 patients attending in the last 12 months.

We carried out this focused inspection of the Emergency Department (ED) on 26 July 2021, to follow up on concerns and enforcement action we took after our previous inspection. We also followed the 'Resilience 5 Plus' process. The 'Resilience 5 Plus' process is used to support focused inspections of urgent and emergency care services which may be under pressure due to demands or concerns in relation to patient flow and COVID-19.

Our inspection had a short announcement (around 30 minutes) to enable staff to arrange to meet with us and for us to carry out our work safely and effectively.

At our last inspection in November 2019, we rated the ED as requires improvement overall.

Focused inspections can result in an updated rating for any key questions that are inspected if we have inspected the key question in full across the service and/or we have identified a breach of regulation and issued a requirement notice, or taken action under our enforcement powers. In these cases, the ratings will be limited to requires improvement or inadequate. The focused inspection included a review of a previously issued requirement or warning notice that had resulted in the application of a ratings limiter.

We did not rate this service at this inspection. The previous rating of requires improvement remains. We found:

- The design and use of some parts of the department/premises did not always keep patients and staff safe despite the efforts the department had made during the pandemic. We were concerned with crowding of the patient waiting area in the ED walk-in reception.
- Several areas of the ED, including resus and majors were untidy and cluttered with opened boxes of equipment and other items left haphazardly.
- Two internal door handles inside the mental health assessment room in the paediatric ED were potential ligature points.
- There was no clear signage to indicate which cubicles may have a patient with confirmed or suspected COVID-19 inside.
- Hand hygiene by medical staff sometimes fell below the required standard.

Our findings

- The ambulance triage station was unmanned for 15 minutes and the computer screen unlocked displaying patient details in an area where patients and non-trust staff could access.

However:

- The service provided mandatory training in key skills, including the highest level of life support training. Although much of the training had moved on-line due to the pandemic.
- In most aspects the service controlled infection risks well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- 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.
- The staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- The service had enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix.
- Patient records were kept updated and the various nationally recognised early warning scores, sepsis reviews and other observations and assessments were properly completed.
- Although the service was not meeting the pre-pandemic National performance data four-hour wait time 95% standard, it was level with the current National percentage of 71.4% and the trend was upwards.
- The service made sure only equipment which was in date was available for use within the ED.

How we carried out the inspection

We spoke with approximately 15 staff across a range of disciplines, including nurses, senior nurses, ambulance crew, department consultants trust grade doctors, senior managers and executive leads.

As part of the inspection we observed care and treatment and spoke with 14 patients. We examined 10 patient care records. We analysed information about the service which was provided by the trust.

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

Urgent and emergency services

Inspected but not rated

Is the service safe?

Inspected but not rated

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff, however, not all staff had completed it.

Shortly after we published our previous inspection report the COVID-19 pandemic interrupted normal mandatory training. This has been a significant challenge for the trust to retain or improve the mandatory training compliance due to the COVID-19 pressures. All training had been on hold (except recognition and management of the deteriorating patient and critical care training), and face to face training had either stopped or had been reduced significantly with the number of attendees allowed in a room.

Overtime, much of the teaching where possible had been accessed online. Managers monitored mandatory training and alerted staff when they needed to update their training. The head of nursing received regular updated information on mandatory training from the learning and development department, so there was oversight of compliance. This information was red, amber, green (RAG) rated for identification of those topics that required more attention.

The supplied data showed an increase in training between the waves of the pandemic. At the time of writing (August 2021) mandatory training showed an improvement from our last inspection with an overall green (over 90%) compliance rate for ED staff of 91.35%.

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.

Medical and nursing staff received training specific for their role on how to recognise and report abuse. Mandatory safeguarding training Level 2 for staff working within the adult ED was almost 98% for medical and dental staff and just over 97% for nursing staff.

The hospital had current adult and children and young people safeguarding policies. These provided staff with guidance on all aspects of safeguarding, including female genital mutilation (FGM).

Within the paediatric ED they held a weekly multidisciplinary team (MDT) safeguarding review. The MDT included ED medical and nursing staff, health visitors, social services and the hospital safeguarding team.

There was a safeguarding system built into the electronic patient record (EPR) which flagged up concern alerts to the user. We were shown a current safeguarding concern and how staff followed the system and triggers to identify and escalate the matter. Other safeguarding triggers in the system alerted staff to patients with learning disabilities and frequent attenders at the hospital (4-5 in one month). This would trigger an MDT review.

Urgent and emergency services

Cleanliness, infection control and hygiene

The service generally controlled infection risks well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean, but some areas were cluttered.

The resus, majors area and to a lesser extent the ambulance service assessment room was messy and cluttered. Wrapped single use equipment was laying haphazardly on top of cabinets and on shelving. On the floor in resus, tall boxes of wrapped single use tube equipment had been torn open at the top to quickly extract a tube. This had left some tubes hanging partly out of the boxes. Files were not stacked neatly but laying one on the other amongst other items. Although the areas did not appear unclean, the cluttered appearance raised concerns about how the cleaners could clean the floors, cabinets and shelving properly.

We raised the untidiness of the areas with several senior staff and they all acknowledged the issue. Some agreed the clutter had become embedded into the staff culture of the busy ED areas.

As part of our 'after inspection' data requests we were provided with 11 Perfect Ward – back to basics: Environment inspection reports, dated between 10 May and 15 July 2021. Of these, seven confirmed the areas were not free of clutter (63%). We have not been provided with any evidence of plans to fix the problem.

Cleaning records were up-to-date and demonstrated all areas were cleaned regularly. We heard calls for cleaners over the public address system to attend various areas to clean between patients. We were provided with the ED cleaning schedule which was thorough and scheduled deep cleaning throughout the year.

We saw all staff, with one exception, follow the requirements for personal protective equipment (PPE) and hand hygiene. We saw staff wash their hands between patients. There was a full supply of PPE available to them and sanitising stations throughout the department. Staff were seen to be following the national and local guidelines to protect themselves and their patients from infection.

We were provided with 24 hand hygiene reports conducted by infection, prevention and control (IPC) staff on four days - 4 May, 7 May, 8 June and 6 July 2021. The percentage of staff compliance ranged from 50% to 100% (only three were at 100%, the rest were mainly late 80 - mid 90%). In 14 (58%) of those reports medical staff were the main people not complying with the required standards. It should be noted the staff numbers being observed for the reports could be low, so one or two staff members not washing their hands or wearing gloves will affect the percentages negatively.

There was no 'donning and doffing' room in majors; this room was near resus. Donning and doffing are the terms used to indicate the putting on and taking off personal protective equipment (PPE). These procedures must be done in the correct sequence and after use, items properly disposed of to prevent the spread of infection.

There was new PPE available on trolleys and clinical waste bins for its disposal outside the majors rooms, where COVID-19 positive patients were being treated. We observed a non-ED specialist doctor leave one of the rooms and saw they removed their gloves and face shield but not their face mask. We immediately brought this to the attention of a manager and the clinician was spoken to and advised appropriately.

We were told during the height of the pandemic; isolation precaution notices were used on the doors to identify which cubicles had suspected or confirmed COVID-19 patients. During the inspection, we noted neither cubicle containing

COVID-19 patients had such a notice. As a result, only staff able to access the EPR system would know which patients had a suspected or confirmed COVID-19, unless they were told specifically. There was a risk porters and cleaning staff may not be informed of the patient's status and therefore they were at risk. When we saw a cleaner enter one of the rooms, they were wearing PPE, which helped in reducing the risks to them.

Environment and equipment

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

The original Edwardian King's College Hospital building had grown and been reconfigured to better suit the requirements of a modern trauma, specialist and teaching hospital. We were told notwithstanding the regular adaptation of the environment the current ED layout still presented challenges because of the physical building.

When children and young people (C&YP) arrived at the ED reception they were directed past the general ED streaming desk to an entrance to the ED paediatric area. There they were streamed according to the level of treatment required. This was also where they were asked the COVID-19 questions before admittance to the paediatric area.

C&YP who were COVID-19 positive or had respiratory conditions went straight to paediatric majors. Since our last inspection six individual cubicles with doors had been created, which provided a good level of infection control and patient safety.

A room within the paediatric ED area had been renovated as a mental health assessment room for children and young people. There was patient friendly corner free moulded furniture and a lot of work had been done to provide a ligature point free space. This was an improvement since our last inspection. However, we noticed both doors had normal push down handles on the inside which could be used to attach a ligature. Following our inspection, the trust informed us that anti-ligature door handles had been ordered and until they were fitted no patient would be left in the room alone.

The Urgent Care Centre (UCC) within the ED was a very busy unit consisting of eight consulting rooms, five treatment rooms and an ophthalmology (eye treatment) room. The UCC was next to the X-Ray department, so tests could be completed quickly. The UCC was where those patients who transported themselves to the ED and were triaged as suitable to be seen by a GP would be assessed. Many patients had been sent to the ED after speaking with the 111-telephone service. Some patients arrived believing they had an appointment only to be asked to join the queue. This was a source of friction between patients and staff at times. To manage this the hospital had switched off the ability for 111 to make appointments. There were also several patients present in the ED who reported that they had been unable to get an appointment with their own GP.

We saw patients having to sit or stand for long periods of time before they could be seen. Most people we spoke with were content as they knew they would eventually be seen by a doctor. Additional sitting and waiting space in the Golden Jubilee meeting area was available, but only outside of normal hours, when it was managed by a health care assistant (HCA).

The majors area within ED had 15 rooms with doors and two mental health (MH) rooms, which were ligature point free and fitted with security cameras. We were told MH patients were moved into majors if they were waiting for a bed.

At the time of our inspection there were two COVID-19 positive patients in two of the rooms with doors.

Urgent and emergency services

Resus had 10 cubicles with doors. Some of these were negative and some positive pressure cubicles. Negative pressure means that air flows into the cubicle but not out providing isolation of infectious patients. Positive pressure means outside air cannot enter protecting vulnerable patients from infection. There was also a relative's room.

We saw one patient on a bed behind a portable screen but close to a storage area, which they could reach if they chose to. This patient had been treated in resus and was waiting for a bed elsewhere in the hospital. He had been moved to free up a cubicle so another patient could be treated.

The ambulatory majors assessment (AMA) unit was closed when we arrived on site as there were not enough staff available to operate it and provide the correct levels of patient safety and care. Staff being absent due to Covid-19 was given as the reason for the drop in staffing levels. By early evening we were told some staff had agreed to stay on shift so the unit could be opened.

The ambulance service assessment area was situated next to the ambulance entrance and triage/handover area. This area contained five beds for non-respiratory patients and enabled the ambulance crews to handover the care of their patients to hospital staff and resume their own duties. They had 'fit to sit' for patients who did not need to be on a bed or ambulance trolley.

The clinical decision unit (CDU) was not in use and had been repurposed as an overflow waiting area with chairs for patients awaiting the results of tests such as computed tomography (CT) scans.

We examined equipment within two resuscitation trolleys and three drawer stacks. The service now managed their stock control of single use consumables well. Staff had ensured only items within date were available for use. This was an improvement since our last inspection. In addition, the resuscitation trolleys were secured, and safety checklists were now properly completed and up to date. This contributed to patient safety.

We noted the larger pieces of equipment within the ED areas had been tested for and were within date for electrical safety. The disposable patient curtains were also within date.

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.

We inspected the ED one week after the government relaxed most COVID-19 restrictions on 19 July 2021. Senior hospital staff told us changes had been made to the layout and patient flow after that date. Patients arriving at the walk-in entrance to ED came into a relatively small area with fixed metal seating. The seating had the social distancing crosses on every other chair but there was little evidence of social distancing as the area became busy. Patients were advised to wear masks within the hospital. Just inside the hospital's main entrance was a security guard and a box of masks and hand sanitizers. No such facilities existed outside or inside the ED reception area.

Many waiting patients were not wearing masks. Patients then waited together before being called forward to a triage/streaming desk. Patients were only then asked questions regarding COVID-19.

Urgent and emergency services

The trust had made the decision to use senior nursing staff to stream the patients on the basis they were experienced and had better knowledge of any ED capacity issues. They also had the skills to take observations and make assessments if UCC or other areas were full. There was one streaming desk, but up to three could be used if demand required. Patients were asked medical questions which could be overheard by other patients. However, a room to the side of the main streaming desk was used if patients wanted privacy.

The department was pre-alerted by ambulance staff for those patients who were critically ill and on their way to the department by ambulance. Hospital staff were then able to plan prior to arrival.

The ambulance arrivals came into the hospital via a different entrance to pedestrians. The crews brought their patients into the triage/handover area where a member of hospital ED nursing staff would register them into the system. The patient was then taken to whichever area of the ED or hospital decided by the triage.

Should the hospital not be able to immediately find a bed for the patient the ambulance crew remained with them. If any patient's condition deteriorated (worsened) the ambulance crew would notify hospital staff. We saw one such patient being held in the triage area for over an hour. The hospital did not have a 'corridor' policy where patients waited in the corridors outside of the main ED areas. The ED received 92 ambulances in the 24 hours of our inspection day, the highest number in the south London region that day. This contributed to the delay in accessing a bed/trolley in the department.

If staff were concerned about a patient's mental health, they had 24-hour access to a mental health liaison and specialist mental health support.

All patients were assessed for their risk of COVID-19 when they were streamed and directed to the correct pathway. Laboratory results for COVID-19 tests were available with a one-hour turnaround. Out of normal hours turnaround could take up to three hours.

Staff made good use of board rounds in resus, majors, paediatrics and UCC. Board rounds are a summary discussion by the staff involved in the care of the patient. They facilitate allocation of the daily tasks required for the patient to progress and identify and resolve any delays in the patient's hospital stay.

To ease patient flow there was an additional porter on duty between 10:00 and 22:00 hrs.

Records for paediatric patients were still paper based but all adult records were updated and stored on the electronic patient record (EPR) system. We examined 10 patient records and found, where required, all now had properly completed paediatric early warning scores (PEWS), national early warning 2 scores (NEWS2), neurological observations and falls assessments.

The EPS automatically flagged a sepsis review for a NEWS2 score of 5 or above. Sepsis is the body's extreme response to an infection. It can be a life-threatening medical emergency. The hospital uses a nationally recognised 'Sepsis 6' pathway to identify and monitor patients.

Staff shared key information to keep patients safe when handing over their care to others.

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

Urgent and emergency services

Staffing

Nurse staffing

The service had enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

During our inspection the ambulatory majors assessment (AMA) unit was unable to open because several staff were self-isolating due to Covid-19.

Nursing staff we spoke with said they were physically and mentally exhausted after working through the COVID-19 pandemic but generally felt supported by their line managers and the executive team. Two nurses said they had not felt supported when the ED was crowded, and the processes were not working properly.

Newly qualified nurses and midwives were supported through preceptorship. This is a structured period of transition where nurses and midwives are supported by an experienced practitioner (a preceptor). It is designed to help develop confidence and enhance competence, critical thinking and decision-making skills.

The ED department was recruiting for a Band 5 nurse, but staffing rates in each department was generally good, allowing for holiday and sickness. We were provided with figures for the use of agency and bank staff between February and July 2021. The percentage of shifts filled by agency nurses was an average of 5.5% and for bank nurses it was an average of 19.8%. An NHS staff bank is an entity managed by a trust, or through a third-party organisation who contract healthcare professionals to take on temporary shifts at trust hospitals. This reduces the number of higher cost agency staff required.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.

The consultants and junior doctors we spoke with told us they felt supported by the ED team, their line managers and the executive team. We found there was good consultant presence in the ED areas. There was consultant cover seven days a week, for at least 16 hours a day within the ED and consultants provided 24/7 cover in trauma. The paediatric ED had a paediatric emergency medicine (PEM) consultant with dedicated clinical floor time.

We were told there were no locum consultants and all locum doctors were supervised. A locum is a person who stands in temporarily for another member of the same profession and is an alternative to agency or bank staff.

We were provided with figures for the use of agency and bank staff between February and July 2021. The percentage of shifts filled by agency doctors was an average of 0.8% and for bank doctors it was an average of 14.3%.

The ED had a designated ‘Orange Doctor’ who was available to respond to the most unwell patients arriving at the department. This doctor was responsible for ensuring early review of all patients who were triaged as category 2; the nursing team could also contact this doctor for any other patients they were worried about. This system ensured patients who were unwell were seen promptly and treatment was started as quickly as possible. This system has seen a significant improvement in time to first clinician for these patients. The ‘Orange Doctor’ name comes from the colour assigned to category 2 in the software the hospital use.

Urgent and emergency services

Is the service caring?

Inspected but not rated

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients in a respectful and considerate way.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Patients told us they were happy with the level of care they had received and those waiting to be seen were content to wait as they understood they would see a doctor eventually.

We noted patients in beds had water jugs and beakers within reach. The call bells were also placed where they could be used easily.

We observed a code 10 call in Majors. Code 10 was used to notify staff of a patient who may have mental health issues and was getting agitated. The security team and ED staff handled the call sensitively and were calm in their approach. They asked him to walk with them to a curtained cubicle where his needs could be addressed in privacy.

The Friends and Family Test results for the ED showed 80% of patients (1652 responses) would recommend the ED at King's College Hospital.

Is the service responsive?

Inspected but not rated

Access and flow

People could not always access the service when they needed it and received the right care promptly.

The National performance data for ED's includes a four-hour wait time. The operational standard is at least 95% of patients attending A&E should be admitted, transferred or discharged within four hours. Since the pandemic the average for trusts in England had fallen from 79.5% in April 2021 to 71.4% at the start of August. The average for the London region fell from 83.3% to 75.5% over the same time period. The ED at King's College Hospital fell from 76.04% to 71.4%, although the trend was upwards at the time of our inspection.

At the start of August 2021, patients being streamed to the ED resus was 4% higher than the London region and 5% higher for paediatrics. For those streamed to UCC to see a GP, the ED matched the London region at 31% above the figure for England.

Urgent and emergency services

The UCC was seen as a blockage area by ED staff we spoke with and we saw the full waiting area and people queuing around the entrance. The trust told us there were plans to have the UCC operated by a different care provider to free up their staff and improve flow.

The above data bore out what staff told us on the inspection day about the pressures placed on the ED by the difficulty getting a GP appointment and those patients directed to the department by 111.

The percentage of type 1 attendances at ED and treated within 60 minutes was 51.6% against the England and London region at 37% (Type 1 ED department = A consultant led 24-hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients).

For patients arriving by ambulance taking handover of the patient brought into the ED quickly freed up the ambulance crew to return to their duties. The percentage of ambulance attendances taking 30-60 minutes to handover to the ED was 12.8% above the England figure of 10%. Yet the percentage of patients waiting over 60-minutes to handover was 0.5%, which was lower than the England average of 4.6%. On the day of inspection, the ED received 92 ambulances, spread over the 24-hour period.

During the early evening we walked into the ambulance triage/handover area and saw there was no member of staff at the streaming desk. In addition, the computer was not locked, and we could read the last patient's details on the screen. There was a member of the public sitting in the area with her young child. This was breach of patient confidentiality and data protection. An ambulance crew from the south-east with a transferred patient then entered the area. They had to wait 15 minutes before a member of ED staff arrived to book them in.

The ED had noted a marked increase in attendances by those patients exhibiting signs of deteriorating mental health, particularly those under 18 years of age. The shortage of mental health beds often meant patients remained longer than was desirable within ED.

The local mental health trust is situated opposite the ED. If the police detain a person under section 136 of the Mental Health Act, they are advised to take them to the local mental health trust for care, control and a place of safety under the Act. However, staff told us if there were no available beds many 136 patients were brought to the ED. A psychiatric liaison team was based in the UCC, in addition SLAM and *Child and Adolescent Mental Health Services* (CAMHS) staff were also based in the hospital. The trust had recruited three Band 3 Health care assistants to assist with one to one care for those patients with mental health needs.

The hospital had recently introduced a new patient discharge lounge to assist with moving patients out of the hospital. Moving admitted patients from the ED to beds elsewhere in the hospital relied on those beds being available. Staff told us patients often had to remain in ED until a bed became available. Senior staff explained as a specialist stroke unit, the hospital frequently admitted patients transferred from other hospitals in the south-east. It was often difficult to return the patient to their original hospital as the bed had been taken by another patient. This caused a blockage in patient flow. There were similar problems with neuroscience patients.

Is the service well-led?

Inspected but not rated

Urgent and emergency services

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Both King's College Hospital and the Princess Royal Hospital had site chief executives who were members of the executive board and reported to the chief executive officer. This meant each hospital site had a board member to oversee the site leadership team, ensuring services provided optimum patient care, quality, safety and experience.

There were 25 care groups within the trust. All the care groups had a clinical director, general manager and a head of nursing. The King's College Hospital ED care group held regular governance monthly meetings, during which patient safety, incidents, risks, previous incident reports and complaints were reviewed and discussed. The clinical directors had regular meetings and worked together across the care groups. We were told patient flow was identified as the top risk in ED. The hospital had recently introduced a refer and move policy. The aim was to get patients referred to other areas, such as the frailty assessment ward, to be moved and assessed in those areas rather than have ward medical staff attend ED.

Leaders we spoke with understood the challenges with quality and sustainability and were able to identify the actions required to tackle them. The managers acknowledged the department was still on a journey of improvement and the past year of the pandemic had delayed some of their planned actions.

The ED had their own clinical lead, matron and lead nurse who reported to the senior team. We were told four working groups had been set up within the quality improvement (QI) team to improve things like rapid assessment and confidentiality.

Regular meetings between the matrons, sisters and staff nurses and attended by the ED head of nursing took place to discuss what was happening within the department. Information was then fed back to the executive team.

Culture

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

The trust was invested in the wellbeing of their staff, especially considering the sustained pressure staff had faced and were still experiencing due to the pandemic. There was recognition that the wellbeing and morale of staff was impacted over the past year. We were told a period of recovery was required to help boost morale and staff welfare and to encourage post-traumatic growth with more engaged teams and individuals.

Monthly departmental Schwartz round sessions were being set up. Schwartz rounds provide an opportunity for staff from all disciplines across a healthcare organisation to reflect on the emotional aspects of their work.

In March 2021, it was announced King's College Hospital NHS Foundation Trust had won the Health Service Journal's (HSJ) workforce initiative of the year for their COVID-19 Staff Support and Wellbeing Programme.

In April 2021, the trust launched its staff recovery programme consisting of five elements; training for managers, recognition, reflection, reflect and reset conversations and mental health self-assessment.

As the trust transitioned into COVID recovery, they developed the role of mental health champions supported by NHS England and NHS Improvement. Twelve Senior medical and nursing staff were identified to undergo the REACT (Recognise, Engage, Actively listen, Check risk and Talk about specific actions) training to be able to support and recognise staff who were at risk of mental distress.

A new appraisal system had been introduced to include a reflective conversation post-COVID-19.

There had been an increase in staff reporting mental health issues. The trust employed a lot of international nurses and not being able to get home to visit during the pandemic had an impact. The trust was being flexible with leave and rotas to enable staff to visit family.

The hospital had set up well-being hubs, which had been well used by staff to separate themselves from the work they did. Staff were offered six sessions of one to one counselling support.

The Trust's senior clinical psychologist was due to commence a newly created post within the staff psychology team, with a dedicated support function for ED staff.

In a recent survey of ED staff 63% of the people who responded said they were happy with the support they got from their immediate line managers.

In June 2021, the trust appointed a new full-time director of equality, diversity and inclusion who was part of the core leadership team reporting directly to the chief executive.

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.

The ED had its own risk register which was reviewed monthly at the ED governance meeting. We reviewed the register and found the risks were updated with actions and next review dates on a regular basis. The ED risks were fed into the overall risk register for the hospital.

Serious and amber incidents, as well as complaints and incident investigation reports were also discussed at the ED governance meetings.

We reviewed the emergency care (DH) care group patient safety report for May 2021. There were no serious incidents recorded. The highest number of incidents were recorded in the majors area, and the majority (55 out of 64) were of a violence or involved security being called. Security staff had a constant presence around the ED.

There was a monthly ED medication safety group meeting to discuss medication alerts and updates medicines incidents. Meetings included discussion, with notes to review or follow-up as required.

The routine audits which had been suspended because of COVID-19 were now being reinstated, as were staff appraisals.

A patient experience group had been established. The group members were medical, nursing and administrative staff as well as the patient experience team. The group met regularly and reported to the ED patient outcomes group.

Urgent and emergency services

For deaths that had occurred within the emergency department, mortality and morbidity data was discussed at weekly meetings and documented as part of the clinical governance for the department and was reported to the trust mortality monitoring committee. The meetings were attended by at least two consultants, a nurse consultant or matron, nursing staff and when required a pharmacist. A list of all inpatient deaths was shared with clinical directors within each care group. We saw evidence of learning from the review of unexpected deaths.

Areas for improvement

MUSTS

The trust must ensure patients attending the Emergency Department are protected from potentially mixing with patients who have COVID-19 symptoms. (Regulation 12(2)(b))

The trust must ensure the internal door handles of the paediatric mental health assessment room which pose a ligature risk are replaced with alternatives. (Regulation 12(2)(d))

The trust must ensure the various areas of the Emergency Department are kept tidy and visually free from clutter. (Regulation 17(2)(b))

SHOULDS

The trust should ensure adequate signage is used to identify locations where suspected or confirmed COVID-19 patients are being treated without having to access a computer.

The trust should consider further reminders to medical staff to practice good hand hygiene.

The trust should ensure all staff are reminded of the requirement to lock computer screens before leaving them unattended to prevent data protection breaches.

The trust should ensure the triage/streaming staff in the ambulance reception area do not have to leave their position unattended.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector and a specialist advisor. The inspection team was overseen by Nicola Wise, Head of Hospital 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