North Middlesex University Hospital NHS Trust

North Middlesex University Hospital

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**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 North Middlesex University Hospital

Inspected but not rated

We carried out this unannounced focussed inspection of the emergency department (ED) at North Middlesex University Hospital in July 2022, in response to concerning information we had about the quality of care in this department. CQC had noted the number of ambulances being delayed from handing over their patients was high which contributed to the reasons for inspecting the service. In addition, many patients who attended the department needed to wait for longer than expected before they received treatment.

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 and being streamed to one of the treatment areas or arrive by ambulance via a dedicated ambulance-only entrance.

At our last inspection in January 2020, we did not rate the department as this was responsive a focused inspection. The emergency department service was rated as good overall in October 2019 when we carried out a comprehensive service inspection.

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

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients acted on them and kept good care records.
- Managers monitored the effectiveness of the service and made sure staff were competent.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.

However:

- Although people could access the service on many occasions, they had to wait too long for treatment. Patients experienced long waits with many patients spending more than four hours before being discharged or admitted to the hospital.
- Many ambulances were unable to leave the departments within 60 minutes from their arrival.
- Not all staff were up to date with their infection prevention and control training.
- Although patients were being kept safe, there was no evidence of hourly safety checks being consistently recorded as staff did not keep an accurate record to demonstrate they were taking place in regular intervals.

Urgent and emergency services

Inspected but not rated

Is the service safe?

Inspected but not rated

We did not rate this domain at this inspection.

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.

All staff received training specific for their role on how to recognise and report abuse.

Female genital mutilation (FGM) training was covered at clinical corporate induction and as part of annual updates for specific staff groups. It was also covered in level 3 safeguarding training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff followed safe procedures for children visiting the department. Children used a separated paediatric ED area that was secure and had a suitable staff presence. Staff received an adequate level of training in safeguarding children and young adults.

We did not identify trends indicating a higher number of safeguarding reported and/or other notifications related to ED. Similarly, there were no identifiable patterns that could be identified through complaints made to CQC by patients, staff, or analysed incidents.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas were clean and had suitable furnishings which were clean and well-maintained.

Staff cleaned equipment after patient contact. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Urgent and emergency services

The service carried out PPE compliance observational audits in April and June 2022. Staff that did not fully comply with the PPE requirement were reminded of the necessity to adhere to it by the person undertaking the audit.

Staff hand hygiene compliance was checked by a member of the team who carried out monthly guidance observational audits. We saw that staff had access to and regularly used hand washing facilities as well as sanitised hands before and after contact with the patient or their surroundings.

92% of non-clinical and 83% of clinical staff working within the medicine and urgent care department had up-to-date infection control and prevention training in July 2022. The trust set a training compliance target at 85%. After the inspection the trust told us they delivered a number of infection prevention and control training sessions which improved compliance with this mandatory training to 87% (August 2022).

Environment and equipment

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

The trust carried out environmental audits as part of the infection prevention and control audits.

Patients could reach call bells and staff responded quickly when called.

The design of the environment followed national guidance.

Staff carried out safety checks of specialist equipment.

The service had suitable facilities to meet the needs of patients' families.

The service had enough suitable equipment to help them safely care for patients.

Staff disposed of clinical waste safely.

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.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. To monitor if escalation was carried out appropriately, each month the department reviewed a random sample of patient notes. The audit in June 2022, indicated that 96% of patient's vital signs were measured on their admission and 83% NEWS were calculated. 94% of patients had their pain assessed within the first hour from arrival. The audit also checked if staff undertook fall assessments and undertook skin integrity assessments among other records. Results of the audit were presented at the department's monthly governance meetings and team managers' meetings. Checks included the documentation of the patient's vital signs, national early warning score card completion (NEWS), a safety checklist and other regular notes recorded throughout the patient stay. NEWS records reviewed at the time of inspection were complete and staff acted appropriately when the patient's score was elevated indicating deterioration.

There was an emergency medicine consultant on site every day until midnight and available after this if required. There was also an on-call paediatric consultant available for critically unwell children. The escalation protocol described the

actions required and the frequency of repeating observations. All medical staff working in the department had completed adult advanced life support training and those working with children received paediatric advanced life support. 85% of nursing staff working at the paediatric ED completed paediatric immediate life support training. 75% of clinical staff (doctors excluded) allocated to the adult ED had up-to-date immediate life support training.

Staff knew about and dealt with any specific risk issues such as recognising and responding to sepsis, falls, and pressure ulcers. Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Safety checks were carried out hourly to ensure the correct procedures were being followed and the adequate standard of care was being provided to patients. Depending on the duration of the patient's stay, each hour goal should be appropriately completed and recorded accordingly. Safety check monthly record audit carried out by the department indicated that the majority of patients had their first- and second-hour checks completed. However, overall, less than 50% of patients had third- and fourth-hour checks recorded.

The quality review of the stroke service undertaken by the London Stroke Clinical Network in October 2021 highlighted areas for improvement in the ongoing care of patients after repatriation from the local hyper-acute stroke unit (HASU). The trust had responded with an action plan to address this and was working towards making progress.

The department recorded time from patient registration to triage for patients arriving by ambulance. The median time to initial assessment for patients arriving by ambulance varied between 23 and 30 minutes between April and July 2022. The department had a system when they prioritised patients who required immediate treatment and had suitable oversight of the patients' waiting area to monitor any potential deterioration in the patient's condition.

The overall median time to treatment calculated from patient registration to the time they were seen by a clinician varied between 132 and 150 minutes between April and July 2022. Approximately 5.3% of patients returned to ED within seven days from the day they were discharged (unplanned re-attendance; April – July 2022).

The service had 24-hour access to mental health liaison and specialist mental health support. Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

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.

Staffing

The service had enough 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 and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service had reducing vacancy rates and low rates of bank and agency staff.

Managers, when deciding to use bank and agency staff, requested staff familiar with the service. They made sure all bank and agency staff had a full induction and understood the service.

Urgent and emergency services

The service had a good skill mix of medical staff on each shift and reviewed this regularly. During the day, staffing numbers varied in line with activity levels. There were between one (10 pm to Midnight weekdays) and four (1 pm to 4 pm weekdays) consultants on shift during the day (establishment set at 17 whole time equivalent). The service always had a consultant on call during the nights (Midnight to 8 am).

The nursing staff establishment was set at 17 nurses per day and 17 nurses at night. The trust in May 2022, increased the establishment temporarily to 21 nurses and was in the process of reviewing the arrangement. The ED brought in additional staff at busy times such as Mondays and Friday and Saturday nights.

The service was able to cover nearly all medical staff shifts from April to June 2022. However, on occasions, they were unable to fill nursing shifts required. For example, in April 2022 only 84% of nursing shifts were covered in the paediatric emergency department with even fewer (78%) of shifts covered in May 2022.

Is the service responsive?

Inspected but not rated

We did not rate this domain at this inspection.

Access and flow

People could not always access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were below national performance, although ambulance off-loading times were worse than national performance.

The ED's leadership team had regular meetings with the local ambulance service providers' management team. They discussed any access and flow issues and initiatives that would reduce the handover waiting times and streamline patients' pathways. Staff working for the ambulance service provider told us they were satisfied with the efforts made by the ED team and thought the team actively sought ideas that would improve patients' experience.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets.

The median time, of a patient stay in ED across June and July, was approximately 213 minutes (arrival to discharge, admission, or transfer; April – July 2022). Walk-in patients upon their arrival were provided with up-to-date information on what the longest wait to be seen by the doctor in the ED was, how many patients were waiting to be seen, and what the total number of patients in the department was.

Between 13% and 16% of patients treated at the ED arrived by ambulance (April – July 2022). On occasions, ambulances were required to remain at the hospital for longer than 60 minutes proving care and treatment as the ED staff experienced delays in handovers (breaches as a percentage of ambulance arrivals). In April 2022, 8.6% (224) of all ambulances that handed over patients to ED staff stayed on site for over 60 minutes. In May 2022 8.7% (247) and in June 2022 it was 7.1% (179). Hours lost to ambulance handover delay had reduced since the winter of 2021/2022 but remained much higher than the same months in previous years. We observed that the ambulance handover process was effective at identifying patients in need of urgent treatment and local ambulance staff were positive about the trust's approach to minimising risk to patients.

Urgent and emergency services

During the same period, the median conversion rate (the rate of ED attending patients that were admitted to a bed) was 9.3% of all ED attendances. The number of patients spending less than four hours at the department was worse than expected with between 62% and 68% of patients being discharged or admitted to bed within that time. At least 95 per cent of patients attending ED should be admitted to the hospital, transferred to another provider, or discharged within four hours. The national performance at the time of the inspection was 71%.

Managers and staff started planning each patient's discharge as early as possible. However, many patients were required to wait after the decision to admit was made due to limited hospital bed availability; admissions waiting 4-12 hours from the decision to admit varied between 35% and 46% (April – July 2022). Managers and staff worked to make sure patients did not stay longer than they needed to. The trust worked towards improving this metric and patient experience by streamlining discharges from hospital wards and raising awareness of the issue across all hospital staff.

Is the service well-led?

Inspected but not rated

We did not rate this domain at this inspection.

Leadership

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

The ED Care Group sits within the ED, Acute Medicine and Care of the Elderly clinical directorate. The ED leadership team is fully staffed with a Senior Matron, Matron, Clinical Director, Service Manager and Deputy Service Manager.

The leadership team had a good understanding of the challenges they faced including patients living with mental health conditions. Through meetings and various forms of communication they shared and worked to meet these challenges as a team.

Staff we spoke with told us that the ED leadership team were very visible and did all they could to offer guidance and support to staff.

Culture

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

Although often tired and stretched, the vast majority of staff we spoke with were positive about the department and its leadership team. Staff we spoke with felt able to speak to leaders about difficult issues and when things had gone wrong. We found there was an open and transparent culture of learning among staff.

We found that staff were professional, well trained and equipped to carry out their role. Staff did their best to deliver good quality care despite the system pressures they faced.

Urgent and emergency services

Staff and managers did not always feel fully supported by other parts of the trust. There was a feeling among many staff that the ED was taking on an unfair share of the challenges facing the trust.

The trust wellbeing team conducted a local survey called the Hospital Anxiety Depression Score (HADS). The ED conducted these surveys in December 2021 and again in June 2022. The responses indicated that staff were experiencing high levels of stress and it was impacting their mental health as a result of the high demands they are working with. The next review was due in December 2002. In addition, the most recent NHS staff survey results for the ED were significantly poorer than the trust average. In response to the survey the trust had implanted a number of initiatives including increasing the amount of wellbeing support that was available to staff.

Managing risks, 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.

The top three risks on the ED register we reviewed were; Impacted ED service delivery due to imbalance in capacity and demand; Ambulance handover delays and Multi parameter patient monitors in resus. These risks were the same as the ones that staff and managers spoke to us about during the inspection. The ED had mitigating actions in place to reduce the impact of these risks on patient care.

We reviewed the most recent sets of ED governance meeting notes and spoke with staff. The ED had an effective system of managing risk and quality for patients. For example, we noted recent improvements in a clinical process that had significantly increased the number of patients suffering severe pain from sickle cell disease who received pain relief within national guidance of 30 minutes. We noted that this process did not apply to severe pain for all other conditions.

The ED team were very aware of the excessive delays that were preventing ambulances from off- loading patients within the 60minute target. Although much of the causes for this were beyond the control of the ED, the department was working with ambulance trusts to reduce these delays and ensure patients were always kept safe. However, the trust rarely had a LAS senior officer (known as a HALO) on site who would have been able to provide additional support and potentially facilitate the earlier release of ambulance staff.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

- The trust should ensure that it works more closely with NHS ambulance services to review opportunities to allow ambulance crews to off-load patients more quickly.