Barking, Havering and Redbridge University Hospitals NHS Trust

King George Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at King George Hospital

Requires Improvement 

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

In the last year, King George Hospital emergency department saw 44,482 adults and 9,240 children.

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

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

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

Urgent and emergency services

Requires Improvement 

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

- Some modules of key mandatory training had low completion rates.
- The service needed locum and bank staffing to fill medical rotas in the emergency department (ED). The service's medical rota also raised the potential risk that the recommended 16-hour consultant cover in the ED may not be met should the service cross the 60,000 patients a year threshold outlined by the RCEM workforce 2018 guidance.
- Some signage in the department was counter-intuitive or still using pathways that had changed but not been amended on the signs.
- The physical limitations of the ED layout and the need to support a large number of attending patients meant that the service could not always provide for best privacy and dignity when the ED was full.
- The provision of mental health care did not always meet the standards required for safe and dignified care.
- We were told that rapid tranquilisation was not always reported as an incident to the trust. There was a risk that leaders did not have oversight of medicines being used in the department to control behaviour.
- There were still concerns regarding the safe management of time critical medication and ensuring all patient medicines records were identified with patient details including allergies. However, medicines management had improved since our last visit.
- Despite improving since our last inspection, the service did not always meet the established standards for assessment and flow through the department. People could not always access the service when they needed it, and some waited too long for treatment.

However:

- 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 most infection risks well. Staff assessed risks to most patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key support services were available seven days a week.
- Staff treated patients with compassion and kindness and helped them understand their conditions. They worked hard to respect privacy and dignity, and to take account of individual needs, although this was sometimes difficult in a crowded department. They provided emotional support to patients, families, and carers.
- The service planned care to meet the needs of local people and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Urgent and emergency services

Is the service safe?

Requires Improvement 

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

Mandatory training

The service provided mandatory training in key skills, including the highest level of life support training to all staff, however not all training modules had a good completion rate.

Staff received and mostly kept up-to-date with their mandatory training. Records showed that for all modules of mandatory training 82% of all staff were up-to-date. Nursing staff had an average completion rate of 85% and medical staff had an average 77.7% compliance.

There was a small amount of training modules that had low completion rates and required action by the service. We identified that modules such as resuscitation level 4 for adult and paediatric advanced life support had an average completion rate of 43% for medical staff. Other modules with low completion rates included: moving and handling level 1 (nursing staff completion rate 50%), resuscitation level 2 paediatric basic life support (medical staff 17.1% and nursing staff 58.1%) and preventing of venous thromboembolism (medical and nursing staff 7.8%). The trust told us that modules such as resuscitation training had been impacted post Covid due to the availability of trainers and course availability. However, the trust had a plan in place to ensure staff were booked on to the training in order to increase compliance.

The mandatory training programme was comprehensive and met the needs of patients and staff. Training modules were reflective of the training needs for staff to provide safe care to patients. The practice development team had ensured that the training was tailored to meet the needs of patients in the emergency department (ED).

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. The service used an on-line system to review and reminded staff when training needed to be updated.

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.

Nursing staff received training specific for their role on how to recognise and report abuse. Of the nursing staff, 90.3% had completed level 2 adult's safeguarding training and 91.7% had completed level 3. Nurses in the ED who were required to undergo children's safeguarding training had an 81.1% completion rate for their level 3 training. Level 2 training for safeguarding children was 100% for this staff group.

Medical staff received training specific for their role on how to recognise and report abuse. Medical staff had an 82.1% completion rate for level 3 children's safeguarding training. They also had a 93.5% completion rate for level 2 adult safeguarding and 85.3% for level 3.

Urgent and emergency services

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Nursing staff were able to describe safeguarding referrals they had made when patients were at risk of harm. They gained support from the trust's safeguarding team and followed up referrals to make sure that action had been taken. We saw examples of staff addressing safeguard risks in line with the service's policy during our inspection.

Staff followed safe procedures for children visiting the department. Children and adolescents were treated in a separate department with effective security controls. Staff had access to an online child protection register to check if children were at risk of abuse.

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 in the ED were clean and had suitable furnishings, which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Regular cleaning audits showed compliance with cleaning schedules. We saw examples during our visit of how all levels of staff contributed to the cleanliness of the department.

Hand sanitising stations were placed at entry points throughout the hospital, and we observed people using these regularly. There were arrangements for enhanced cleaning, should this be required, and we saw operatives cleansing high-touch points such as chairs, tabletops and door handles.

Staff followed infection control principles, including the use of personal protective equipment (PPE). We observed ED staff complying with good hand hygiene practices and using correct PPE. We noted an improvement in the hand hygiene audits between August 2023, which showed 67.6% compliance with correct techniques, to a 77.6% compliance in September and a sustained improvement to 90% in October 2023.

Staff disposed of clinical waste safely. Needle sharps bins were available throughout the ED and the bins we inspected were labelled and stored correctly.

Staff were familiar with, and adhered to, up-to-date processes for infection prevention control including managing COVID-19 prevention.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Rooms containing cleaning chemicals were locked and met the regulations for the Control of Substances Hazardous to Health (COSHH).

Environment and equipment

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

The adult ED floor comprised of a reception area and working spaces designated as resuscitation, majors, the rapid assessment and first treatment (RAFT) area and a same day emergency care (SDEC) unit. The RAFT unit incorporated the ambulance receiving point. The design of the environment followed national guidance. The department allowed for good circulation space, although some staff identified that when the department was very busy this could be impacted.

Urgent and emergency services

Patients who self-presented to the hospital were required to be streamed by the onsite urgent treatment centre (UTC). The UTC was run by another provider.

Staff at the ED highlighted improvements since our last inspection in relation to this process. As an example, there was now clearer criteria agreed for identifying which patients should be streamed to the ED. The streaming nurse also differentiated vulnerable or potentially high risk/ time critical patients from those following the standard streaming to the ED pathway. The vulnerable/ urgent patients were escorted by the UTC nurse (using a wheelchair if necessary) to the ED via an internal corridor and handed over directly to ED clinical staff.

All other streamed patients were directed to make their own way back out of the hospital building to enter the ED main entrance. This meant that some patients entered the main ED entrance and saw ahead of them a desk marked reception with reference to red and yellow cards. The red and yellow card system was no longer in use. Navigation of this pathway was potentially confusing for patients.

The RAFT area consisted of an assessment cubicle, a sub-wait assessment cubicle with 3 seats and 4 other treatment/ assessment cubicles. These cubicles could also be used as offload areas for ambulance crews. In addition to this, there were 3 locations marked on the floor of the corridor leading up to RAFT for ambulance offloads should the service be very full. We did not see these in use during our visit. This area was well equipped to support the care of patients as well as the safe management of the ambulance offloads.

The SDEC unit was a new addition to the ED since our last inspection. The environment of the SDEC area was clean and bright. Most of the space was occupied by reclining chairs for patients. The 12 chairs were placed close to each other with little individual space for each patient. This did not always provide the most privacy for patients. There were 2 examination cubicles within the unit and 2 more adjacent to allow clinical examination and assessment in private. This area was well equipped and provided staff with the equipment needed to undergo safe care and monitoring of the patients.

The majors' area had been extended and refurbished since our last inspection. There was a total of 19 beds and 2 mental health rooms. The newly built majors' cubicles were of good size and were well equipped with networked monitors in each cubicle. Some of the older majors' cubicles had been repurposed for 2 bedded areas. These cubicles did not always offer ideal conditions for managing 2 patients as they were too small to allow access from both sides of the bed. Despite having curtain dividers this did not always provide the most adequate privacy and dignity for patients. We were informed by staff that patients who were assigned to these beds were those assessed as being of less risk or patients that were required to be in the majors area but were waiting for admissions. However, when the department was busy this wasn't always manageable.

The majors' area had 2 designated rooms specifically for the assessment and care of patients with mental health needs. The rooms had 2 doors, a viewing panel, sturdy furniture, security cameras, an intercom, alarm button, and anti-ligature fittings. One room had ensuite toilet/shower facilities; the other did not. None of the rooms included access to a clock. The facilities for mental health patients were clean, and well-maintained.

The location of the mental health assessment rooms presented a difficulty with other physically vulnerable patients nearby. The non-ensuite room meant patients had to be escorted through these areas to toilet facilities. Additionally, children exhibiting behaviour that was challenging were frequently moved to one of the adult assessment rooms.

Urgent and emergency services

The paediatric area was a separate unit to the main department, with its own entrance and reception area. There was a large waiting area within the paediatric area which was well equipped and easily visible to staff. The paediatric area had 7 bays of which 1 was a resuscitation room which was equipped and stocked to allow for treatment of children of different ages. Equipment available in paediatric department was appropriate for the treatment of children of different ages.

The room used for paediatric mental health patients included ligature anchor points and other risks, so patients could not be left in these areas without supervision, which impacted upon their privacy, particularly during long stays. If the patient presented a heightened risk, the service placed them in the mental health room within the main ED. There were no ensuite facilities available.

The resuscitation area was also recently refurbished having 6 spaces including 1 with doors and negative pressure. This area was appropriately equipped and laid out.

The service used the reception area as an “overflow” RAFT and SDEC treatment area. This was in response to maximising the usage of the department when patients who were assessed to be clinically stable were awaiting results or being monitored prior to discharge. However, the review of the RAFT and SDEC standard operating procedures did not mention this area as part of the patient pathway.

The service had enough suitable equipment to help them safely care for patients. Patients could reach call bells and staff carried out daily safety checks of specialist equipment. We found that all equipment had been regularly maintained and had been checked to ensure that it was ready to use. Where issues were highlighted, risk assessments had been completed and staff were aware of the changes made.

Staff disposed of clinical waste safely. Boxes for the disposal of sharp instruments were well constructed and filled to a safe level. Other clinical waste was disposed of in colour coded bins which were emptied frequently.

Assessing and responding to patient risk

Staff completed risk assessments for patients in a timely way. They removed or minimised risks and updated the assessments in accordance with patient needs. Staff identified and quickly acted upon patients at risk of deterioration. However, despite the improvement in ambulance handovers the service did not meet the national established time standards for ambulance handovers. Additionally mental health patients admitted to the service did not always have timely assessments as there were long waits for patients to be seen by approved mental health nurses for assessment.

During our inspection we saw an improved picture in relation to our previous inspection in November 2022.

Staff at the UTC saw all walk-in patients who were then streamed, triaged, and directed to the adult or paediatric ED, where they would be triaged a second time. We noted an improvement in the cooperation and established criteria for referral between both services.

Adult patients who were referred from the UTC or arrived by ambulance were seen in the RAFT unit for handover and triage. Here a senior 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. To improve the

efficacy of the service being delivered the service had a RAFT assessment cubicle, a sub-assessment cubicle with 3 chairs and 4 RAFT treatment/assessment cubicles. This could be expanded to a 2 further assessment rooms if the footfall in the ED increased. We did not find the same challenges to capacity as in the last inspection as during our visit bays were in constant use but never overcrowded.

As standard, two senior doctors were allocated to RAFT – one for walk in patients and one for ambulance patients. They worked flexibly to support each other. This staffing model had been adopted so that prescriptions could be written and ionizing radiation imaging, including X-Ray and Computerised Tomography (CT), could be requested by the first assessor.

During our inspection we observed the triage of 5 ambulance patients. All were triaged immediately and in line with national guidelines. We reviewed the records of a further five ambulance patients who were admitted during our inspection and found these were managed equally well with 2 handovers being over 15 minutes but under 30 minutes. We were however told by staff that if the department was full, there would sometimes be delays before ambulance patients could be brought into the assessment area.

The service made use of the SDEC area to support ambulatory patients who required short stays for treatment. The service had clear inclusion/exclusion criteria to who should be accepted to the area and patients were observed and risk assessed in accordance with their clinical presentation. Patients within SDEC who deteriorated or required further emergency treatment could be escalated to the majors' department or resuscitation area as required.

Children were triaged by specialist children's nurses. During our inspection this took place within 15 minutes. We requested the percentage of children patients seen within 15 minutes for the last 12 months but were not provided with this data. However, the service carried out an audit to monitor how the complex triaging tool was supporting safe and timely triage of paediatric patients. Data from the July 2023 audit showed that at the beginning of 2023 the average time taken to complete a triage was 9 minutes. With the new process this time was now on mean 4.1 minutes, with most of the assessments being completed in 3 minutes.

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Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. National Early warning scores (NEWS2) were used for adults and paediatric early warning scores (PEWS) for children. This was a quick and systematic way of identifying patients who were at risk of deteriorating. Clinical observations such as blood pressure, heart rate and respirations were recorded and contributed to the total score. Once a certain score was reached a clear escalation of treatment was commenced. We found that all scores were recorded and calculated accurately and regularly, and action was taken immediately should the score identify a risk to patients.

Staff knew about and dealt with any specific risk issues. We looked at the risk assessments for sepsis, allergies, falls and pressure ulcers in 15 patients records. All had been completed in a timely manner.

Urgent and emergency services

The service had 24-hour access to mental health liaison and specialist mental health support. However, there were long waits for patients to see approved mental health nurses for assessment under the Mental Health Act 1983, particularly at night. There were also delays for patients to be assessed by Section 12 approved doctors.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients with mental health concerns. However, the quality of risk assessments was quite basic, with some lack of clarity as to who had responsibility for the patients. Additionally, different electronic systems used by the ED staff, psychiatric liaison services and agency mental health nurses meant records for mental health patients could be disjointed and there was a risk critical information for the care of the patients could be missed. However, if a patient left the unit before treatment and referrals were complete, and the patient presented a risk of harm to themselves or other people, the service would contact the police.

Staff praised the radiology service provided to the ED stating it was very responsive. There were clear pathways for referral for imaging, with referrals usually dealt with promptly and reports provided within the recommended standards. Plain films were mostly "hot reported" while the patient was still in the ED, whereas most ED's nationally provided next day reports for overnight films. This ensured a quick response to any requests. This service was mostly provided by reporting radiographers. In addition to this, the ED had good access to emergency ultrasound by sonographers. Out of hours CT reporting was outsourced and there were no concerns about the quality or timing of reports.

Shift changes and handovers included all necessary key information to keep patients safe. In addition to regular staff handovers, the nurses and doctor in charge of each shift carried out safety huddles and recorded key information from them. They reviewed the electronic records of patients in treatment areas and highlighted new information. They checked that all patients with a high NEWS2 score (patients who were at risk of deteriorating) had been examined by a doctor and treatment started. If there were long waits for other patients to be seen by a doctor, they tried to re-organise staffing to improve the situation and escalated flow concerns to senior leaders and the site bed management team.

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.

The service had enough nursing and support staff to keep patients safe. Nurses that we spoke with told us there was usually enough staff in the department, and we observed good staffing levels during our inspection. However, typical staffing for the resuscitation area was 3 nurses with 1 of those being a senior nurse who took patients and lead the team. This met RCEM guidance of a ratio of 1 nurse to 2 patients, if patients were nursed in that area due to a crowded ED or had been stabilised and were awaiting further investigations or transfer to a ward. Should the resuscitation area have patients during their resuscitative phase of illness or injury, the recommendation to have 1:1 or even 2:1 care would not be met in cases of full capacity. We raised this with senior leaders who identified that should the number of patients and their severity increase in the resuscitation area this would be escalated and more staff would be assigned to the area.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Assurance of safe staffing in the service was checked using a safer staffing tool, professional judgement, activity and flow data, and acuity and dependency where applicable.

The service used bank and agency nurses to complete rotas and to support escalation of services. Duty rotas we reviewed showed that agency nurses were used, and bank nurses worked regularly in the department and were familiar with it. Managers made sure all bank and agency staff had a full induction and understood the service.

Urgent and emergency services

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. However, the service was very reliant on bank and agency medical staffing to complete rotas.

The service had enough medical staff to keep patients safe. However, the service needed agency or bank staff to complete their rotas. Between November 2022 and October 2023 the service had on average 77.6% of their available posts filled with substantive medical staffing. This meant that of the whole-time equivalent budget 18% was completed with bank medical staff and 10% with agency staff.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. However, we reviewed the medical rota plan used for each day in the department and found a potential situation in which the department could have only 14 hours of consultant level cover per day should it meet the 60,000 patients a year threshold outlined in the RCEM workforce 2018 guidance. We raised this with the leadership team who explained to us there was an ongoing review to ensure a consultant was present in the department for 16 hours a day, seven days a week in line with recommended staffing guidelines.

Additionally, we were assured that consultant support was always available for medical staff in the ED with on-call cover being provided by the resident night shift consultant at Queens Hospital.

Managers made sure agency staff had a full induction to the service before they started work. Standard induction information was given to agency staff before they started. Additionally, they were always supervised by more senior doctors.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care. However, the use of different electronic patient record systems within the hospital could lead to delays and potential errors in transferring patient information.

Patient notes were comprehensive, and all staff could access them easily. There was a mix of paper and electronic records. We reviewed 20 patients' records and found them to be clear and detailed.

Electronic records could be accessed throughout the hospital. Copies of patient paper records were sent with them when they were admitted to a ward.

An electronic referral system was in use for referrals to medicine and some other admitting teams in the hospital and trust. The doctors universally praised this system which they said made the safe handover of care much easier. However, the ED and admitting teams used different electronic patient record systems requiring the cut and paste of information from the ED notes system rather than a direct link. This could raise scope for error pasting information from one patient in the ED system into a different system in the referral software. We raised this with the leadership team and were informed that a new electronic patient record system was being installed to replace the current system.

Computers and computer systems were at times unavailable and slow to match the service's needs. We observed that several computers were out of use and were told by staff that this was a frequent problem. We observed slow response of some software used for basic clinical data entry and the need to log into multiple systems for the care of one patient.

Records were stored securely. Paper records were kept in robust containers at the staff bases and at reception, and were always supervised, whilst electronic records were stored securely on digital databases.

Medicines

The service did not always follow systems and processes to safely prescribe, administer, and record medicines.

Staff did not follow processes to identify patients on time critical medicines. Although we did not see patients miss time critical medicines on inspection, we did not see the colour coded stickers being used. There was an ongoing risk that patients would not receive the correct support for ensuring they take their time-critical medications. An audit completed June 2023 showed only 18% of patients who were on time critical medications had their medicines prescribed. Actions included teaching that was to be completed by December 2023 and re-auditing in 2024. Other actions included highlighting patient records with the use of colour coded stickers.

Staff followed policy when prescribing antibiotics. We saw in patient records that antibiotics had clear indications and length of treatment documented when prescribed.

Staff provided advice to patients and carers about their medicines.

Staff did not always complete medicines records accurately. We reviewed 25 records across the department and found that 10 records did not have patient details on the ED medicine administration charts. There was a risk that these sheets could be lost or be untraceable because charts were photocopied when a patient was moved from the department to another ward or unit.

The service followed most policies that were in place to identify patients with allergies including using coloured patient wristbands and confirming allergy status when administering medications. However, not all medicine charts we reviewed had allergies filled in as per policy. Doctors told us that it could be time consuming to check allergy status if it was not clearly documented in patient's paper records.

Self-administration of medicines was managed by the patient and there was a trust policy for the self-administration of medication which detailed the process. However, this was not always followed. As an example, we saw a patient administering their own insulin, but it was not clearly highlighted on their ED record. There was a risk that staff could administer duplicate doses of a patient's medicine. This patient also had no documentation of risk assessment being done around self-administration. There is a risk that patients, if not suitably assessed, may not be able to self-administer safely. Issues around self-administration in the ED were highlighted in our previous report, and in previous governance meeting minutes as recent as October 2023. We highlighted this to the lead pharmacist who was acutely aware of the issue but had not been able to address it beyond the action plan from the previous report, due to prolonged absences from themselves and other senior leaders.

Medication administration records in the ED did not contain space for dates of administration. Dates of administration should be recorded when medicines are given as per national guidance. There was a risk that if patients stayed longer than 2 days it may not be clear what day medicines were administered.

We observed that an agency doctor did not have his own access to the electronic system which could delay care in busy periods as he was relying on other members of staff to log him in.

Urgent and emergency services

Staff mostly stored and managed medicines safely. Prescribing documents were stored and managed safely. Staff were able to easily access stock medicines in automated medicines cupboards. Controlled medicines (medicines requiring additional control due to the potential of misuse) were stored securely and medicines requiring refrigeration were stored in temperature monitored refrigerators.

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

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

Staff learned from safety alerts and incidents to improve practice. We saw records of safety alerts being actioned and recorded.

We saw staff following protocols when de-escalating patients so that their behaviour was not controlled by excessive and inappropriate use of medicines. However, agency mental health nurses told us that they would not report rapid tranquilisation as an incident. There was a risk that leaders did not have oversight of medicines being used in the department to control behaviour.

Incidents

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

Staff knew what incidents to report and how to report them. They were confident about the process and received feedback if required.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Investigation reports that we looked at demonstrated this.

Staff received feedback from investigation of incidents, both internal and external to the service. Outcomes of incident investigations, from both the trust's ED were shared and posted in the staff room.

Staff met to discuss the feedback and look at improvements to patient care. Incidents were discussed at ED governance meetings and changes made when necessary.

There was evidence that changes had been made as a result of feedback. As well as patient safety incidents, there were also frequent reports of violence and aggression towards staff. These were discussed at ED staff meetings and also at divisional meetings. As a result, there had been an increase in security staff in the department to improve staff safety. The service kept records relating to the restraint of patients and recorded this on the electronic records system.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. The 3 investigation reports that we reviewed were detailed and followed the correct processes in the investigation method used.

Urgent and emergency services

Managers debriefed and supported staff after any serious incident. Senior staff understood the impact that serious incidents had on staff and provided timely support. We heard evidence of this from incidents that staff shared with us.

Is the service effective?

Good 

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Emergency department staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The trust ensured new guidance from national organisations, such as the National Institute for Health and Care Excellence (NICE) and NHS England were revised regularly and escalated to the department.

The department had an audit programme that monitored the implementation of guidance from national clinical organisations and quality improvement programmes. The audit programme included audits of NICE guidance. The department also took part in national benchmarking clinical audits including those organised by the Royal College of Emergency Medicine (RCEM). We reviewed the service and trust audit plan and were assured that governance process, such as the emergency department (ED) and Geriatric clinical audit and effectiveness report, supported the management and accountability of the audit and that relevant action plans were monitored.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. As an example, they regularly looked after patients subject to Section 136 of the Mental Health Act 1983 and were familiar with the Code of Practice. They ensured that the psychiatric liaison team undertook daily checks of patients while they waited for definitive psychiatric treatment. Staff in the department were also aware of the new protocols coming into place regarding support with mental health patients – 'Right Care Right Place.' Some staff expressed concerns about police availability to support with patients who went missing, and the amount of time police would remain with patients in the 136 suite. (A Section 136 suite is a facility for people who are detained by the police under Section 136 of the Mental Health Act. It provides a 'place of safety' whilst potential mental health needs are assessed under the Mental Health Act and any necessary arrangements made for on-going care).

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. This was an improvement from the last inspection we carried out. We observed support staff carrying out regular refreshment rounds for patients and families. This included patients in the waiting room. Clinical staff regularly checked that patients had received enough to eat and drink.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. The records that we reviewed showed these had been accurately documented.

Urgent and emergency services

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. We looked at the records of 5 patients who complained of pain. All patients had their pain score recorded.

Patients received pain relief soon after it was identified if they needed it, or they requested it. We observed pain scores being recorded and timely pain relief being given throughout the inspection. There was positive feedback from patients regarding the speed of pain relief that was given.

Patient outcomes

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

The service participated in relevant national clinical audits such RCEM audits as well as the participating in the trauma audit and research network. We reviewed the audit plan and saw data was being submitted in a timely and relevant manner.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers used information from the audits to improve care and treatment. We reviewed the service's sepsis audits from May 2023 to October 2023 and found that actions were taken to address improvement areas. These were then reevaluated to assess their success. For example, the audit identified that documentation of the sepsis 6 pathway could be improved to match the service's compliance target. The service was actively monitoring this and introduced an action plan in which it was identified that ongoing spot checks on noncompliance with the sepsis 6 pathway documentation would be carried out on a shift-by-shift basis. We saw that additional support would be given by the sepsis nurse and sepsis champions and 1:1 feedback provided on how to improve performance.

Managers shared and made sure staff understood information from the audits. Results were discussed at governance and staff meetings. We reviewed action plans to quality improvement programmes such as the pain in children improvement plan. We were assured there was oversight and good sharing of information relevant to the improvement of the service. We were assured that the questions used for the analysis, commentaries and recommendations were recorded in line with best practice and implemented to improve services.

Competent staff

The service made sure staff were competent for their roles. The service held supervision meetings with staff to provide support and development. We were told managers appraised staff's work performance. However, some staff felt they needed protected time to ensure training and development opportunities were not missed.

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

Managers gave all new staff a full induction tailored to their role before they started work. This included a support programme for overseas staff, to ensure they were familiar with the services' processes and procedures before working independently.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Training needs were a key part of the appraisal process.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Supervision sessions were held regularly and compliance with annual appraisals monitored. All conversations were confidential so that staff felt more comfortable in raising concerns.

Managers supported staff to develop through yearly, constructive appraisals of their work. Nurses spoke positively about the appraisal process. We reviewed the number of completed annual appraisals for the trust's frailty, acute medicine and emergency division and found that 68.8% of the division's staff had their annual review completed. The percentage of King George Hospital accident and emergency nurses who had an annual review was 75.9%.

The foundation doctors at the service had a trust based formal education program provided as blocks of 3 hours once a month. This time was protected. A doctor we spoke with who had completed the foundation program felt that this program was ad hoc and not well structured to meet the foundation program doctors' needs. There was a weekly program of brief "sound bite" teaching sessions delivered on the shop floor by emergency medicine consultants to the doctors on duty at that time. The quality of these sessions was rated very highly by the junior doctors we spoke with however, this was only once a week, and only a small proportion of the doctors were able to access each session. A cross department teaching program was delivered weekly by video link from Queen's Hospital. This was one hour directed at senior doctors and one hour directed at juniors. This time was not protected so was mainly accessed by doctors off duty in their own time.

All trainee, speciality and associated speciality and locally employed doctors had a named educational supervisor consultant who met them at the same frequency as would be required for trainees. Separately to this all doctors had appraisals by a trained appraiser.

Clinical educators supported the learning and development needs of staff. They had developed a comprehensive starter pack for newly recruited nurses and had established development targets in line with the Royal College of Nursing's National Curriculum and Competency Framework for Emergency Nursing.

Nursing staff had only received a basic level of training in mental health. The trust employed agency RMNs to support people with mental health needs. Registered general nurses within the department did not carry out any restraint techniques on patients. However, managers indicated that there were plans for them to have training in this area.

Staff were completing the Oliver McGowan training on working with people with learning disabilities or autism.

Multidisciplinary working

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

Staff held regular, effective, multidisciplinary meetings to discuss patients and improve their care. We attended and were shown minutes of these meetings and found these to be comprehensive and supportive of safe patient care.

The local mental health trust delivered a psychiatric liaison service to provide mental health assessments, referrals, care and treatment to patients aged 18 or over. Staff working for this service were based on site. There was a service level agreement between the psychiatric liaison service and the ED since 2015. The service level agreement included a target for the psychiatric liaison service to respond to 95% of requests to assess patients within one hour. The service carried out psychosocial assessments in accordance with national guidelines.

Urgent and emergency services

Staff at the paediatric ED said the service had a very good relationship with the local specialist child and adolescent mental health service provider.

We observed ED staff working seamlessly with ambulance staff and with the hospital and trust specialities to improve the care of patients. Handovers were effective and supported the patients care needs.

Pharmacist support was available in the department to provide medicine advice to patients and staff if required. In person support was available Monday to Friday between the hours of 9am and 5pm. On call support was available from the pharmacy department outside these hours.

There were well established links with the hospital frailty team, therapists, and primary care practitioners as well as specialist interest groups supporting dementia and learning disability patients.

Seven-day services

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

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week. ED consultants provided cover 24 hours per day, 7 days per week, either directly within the department or on-call. Relevant diagnostic services were also available whenever needed.

The paediatric service could refer patients to the local specialist child and adolescent mental health service provider between 9.00am and 5.00pm from Monday to Friday. There were sometimes delays in the service attending the ED, over the planned target of 2 hours of ED staff requesting an assessment. Outside these hours, staff could contact an on-call specialist psychiatrist.

Health Promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units.

Staff took the opportunity, if it arose and was appropriate, to discuss topics such as smoking cessation and drug and alcohol misuse with patients. There were leaflets and contact details of relevant organisations that may be able to offer support and advice to patients.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. We observed staff discussing patients' capacity to make decisions and using a standardised process to assess capacity.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. They asked for consent before invasive or intimate procedures and recorded consent in patient records.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. The staff we spoke with had a good working knowledge of the guidance for gaining valid informed

consent from a child. They were aware of the legal guidelines which meant children under the age of 16 were able to give their own consent if they demonstrated sufficient maturity and intelligence to do so (Gillick competency). Otherwise, consent would be sought from the child's parent or guardian. If a child attended without a person who was able to provide consent, staff would attempt to contact an appropriate adult.

Clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Mandatory training completion rates for these modules showed 80.3% of nurses had recently received this training while doctors had an 81.1% compliance with this module.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff reported largely complying with the section 136 timescales of 24 hours, sometimes extending these by an additional 12 hours. However, in cases where patients detained under section 136 were assessed by a doctor and found not to have a mental health condition for which they could be detained, staff reported a delay in patients being advised that they could leave, whilst they waited for an approved mental health practitioner (AMHP) to see the patient. Although they said that they would not stop a patient from leaving in this situation, they were not always letting patients know that whilst it was recommended, they were not obliged to wait for the AMHP before leaving.

Is the service caring?

Good 

We did not rate caring at our last inspection. We rated caring as good.

Compassionate care

Staff treated patients with compassion and kindness. However, staff recognised that during busy periods of time it was not always possible to respect privacy and dignity or to take account of individual needs.

Staff were discreet and responsive when caring for patients. They took time to interact with patients and those close to them in a respectful and considerate way. They were courteous to patients and their families and took individual circumstances into account when deciding on treatment.

Patients said staff treated them well and with kindness. We spoke with 5 patients all of whom were complimentary about the kindness they had received. One said "You cannot fault the staff here. They have been marvellous." We also viewed recent written feedback from patients which praised the friendly and considerate way in which they had been treated.

We saw an improvement in the standards of care compared to our last inspection to the service. We did not observe any corridor care and were informed that this had reduced significantly with the implementation of the SDEC and improvement to the RAFT area. However, it was not always possible for staff to follow policy to keep patient care and treatment confidential. The use of the reception area as an extension to RAFT and SDEC meant that despite staff taking caution sometimes privacy of patients could be impacted. Staff tried to transfer patients to a room if private conversations were needed but these could be full on busy days. To reduce delays for diagnosis or treatment conversations sometimes had to take place in busy areas.

Urgent and emergency services

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. We observed staff discussing a patient with severe mental health problems. They displayed a good understanding of the patient's needs and the help that they and their family would require.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. They described these needs with insight and empathy.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff gave patients and those close to them help, emotional support and advice when they needed it. They took time to reassure patients emotionally, as well as treating their physical injuries. One patient told us how concerned they were on attending the department, but how staff's patience and kindness helped them to feel better.

Communication with children was well thought out and effective. Staff took time to distract and comfort them during injections and blood tests.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Patients with mental health problems were often nursed in single rooms often with one-to-one care when the mental health rooms were occupied.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. We observed the great care, sensitivity and consideration that was employed when updating the relatives of a very sick patient.

Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them. We observed a member of staff discussing the results of investigations that were worse than expected. They spoke slowly and checked the patient's understanding before continuing their explanation.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. We observed clinical staff introducing themselves and explaining what was about to happen before examining patients. Almost all staff wore name badges which clearly stated their name and role. This helped to ensure that patients were aware of the professionals involved in their care.

Parents were involved in the assessment and treatment of their children and clear explanations were given. We observed family members being included in discussions about on-going care.

Staff talked to patients in a way they could understand and had access to communication aids where necessary. Staff adjusted explanations of treatment depending on the patients' level of understanding. Staff explained how they could use pictures and computer images to aid communication.

Urgent and emergency services

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Although negative feedback had been received about delays in the department, we read 7 recent messages from patients that complimented nursing and medical staff on their professionalism and kindness.

The service used the family and friends test to monitor if patients felt satisfied with their care and if they would recommend the service to their family. 77% of people who replied to the questionnaire and who had used the emergency department's service would recommend it to family and friends.

Is the service responsive?

Requires Improvement 

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

Service delivery to meet the needs of local people

The service planned and tried to provide care in a way that met the needs of local people and the communities served.

Managers planned and organised services so they met the needs of the local population. Facilities and premises were appropriate for the services being delivered.

Some patients came to the hospital with conditions that were neither an accident nor an emergency. The hospital filtered these patients through the urgent treatment centre triage to ensure that suitable patients were directed to the correct clinical pathways.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. Staff spoke of a significant and sustained increase in the number of patients with mental health issues presenting at the emergency department (ED). They noted an increase in homeless patients and in younger men particularly from overseas presenting with mental health issues.

The service was aware that the nearby health-based place of safety was frequently full, and patients were therefore brought to the ED instead. Several patients attended King George Hospital (KGH) from other boroughs and needed to be repatriated in their local area. They noted that KGH was the highest general hospital receiver of section 136 patients in north east London.

Meeting people's individual needs

The service was inclusive and attempted to always take into account patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff tried to make sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Patients with significant mental health problems often spent a long time in the department due to delays in on-going psychiatric treatment. 2 rooms had been adapted to accommodate their needs in

the majors area of the department. Risk assessments had been carried out to ensure they were safe for people at risk of suicide. Arrangements were made for specialist staff to provide care, often on a 1 to 1 basis. However, due to a shortage of in-patient beds, some mental health patients had to spend several days in a room that was designed for a stay of only a few hours.

The ED risk register showed that there were risks for mental health patients spending extended periods of time in the department. Senior staff were aware of this and were working with mental health teams to improve the situation.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Staff were aware of 'This is me' documents but said that patients often did not bring them with them in an emergency. Staff had received training in responding to the needs of people living with dementia. They described the care needed in a knowledgeable and sympathetic fashion. They knew, for example, that patients with dementia should be cared for in a quiet part of the department in a low stimulus environment. We observed this taking place although staff told us it was not always possible when the department was full.

The ED had patient experience trolleys available to support patients with dementia or learning disabilities.

The service had information leaflets available in languages spoken by the patients and local community. Although the leaflets on display were in English, staff told us that they could print them out in different languages if necessary.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. There was a 24-hour translation service available.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Staff told us they would inform support staff if someone had special dietary needs.

Access and flow

People could not always access the service when they needed it or receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

There were systems in place to manage the flow of patients through the ED facilitating the discharge or admission to the hospital. The team could see on the IT system the length of time patients had been in the ED as well as an overview of bed availability and flow of patients coming into the ED which was discussed at regular meetings through the day along with staffing numbers.

Managers and staff worked hard to try to ensure patients did not stay longer than they needed to, but the demands on the service and challenges with access and flow did not ensure this was always achieved.

Managers monitored waiting times and tried to make sure patients could access emergency services when needed and receive treatment within agreed timeframes and national targets. In the past the majors' area had the ambulance handover station linked to it. This had caused delays in diagnosing and treating patients who arrived by ambulance. To reduce these delays an ambulance assessment area had been created in the RAFT area with a senior doctor and nurse present to commence medical assessment and treatment. We reviewed data from November 2022 and October 2023

and despite a significant improvement from the year before this period, the service only met the 15-minute handover standard for 16% of admitted patients. 48% of ambulance handovers were completed under 30 minutes. The trust reported a total of 2060, 60-minute ambulance handover delays in this period. It is important to note that of these delays, only 21 occurred between August and October 2023.

Current waiting times for triage and access to a clinician were clearly displayed in the ED waiting room on a white board. During our inspection the average waiting time observed was 1 hour. This was an improvement from our last inspection which regularly saw waits of 11 hours.

The Department of Health's standard for ED's is that 76% of patients should be admitted, transferred or discharged within four hours of arrival in the ED. Although this target was not met by the service, evidence we reviewed between November 2022 and October 2023 indicated an improving picture against this standard. The service had improved this metric from the lowest point in December 2022 (21.9%) to 50.3% in October 2023. The service had managed to sustain the above 50% marker for 4 months consecutively between July and October 2023.

Managers and staff worked to make sure patients did not stay longer than they needed to. However, there were still challenges with delays in admission, transfer or discharge which continued to be caused by the combination of significant numbers of patients arriving in the department and, restricted flow through and out of the hospital. There were challenges with flow within other specialties of the hospital, as well as a lack of available care in the community for patients to be discharged to. For example, we found delays in transferring patients with mental health needs had an adverse impact on the capacity of the ED. The average time spent for patients in the department between November 2022 and October 2023 was 6.6 hours. However, we saw an improvement in the median time patients spent in the department. The service had progressed from an average of 9.3 hours in November 2022 to 4 hours in October 2023.

There were some positive changes with the flow in the ED. The successful use of the RAFT area for ambulance patient handovers had resulted in an improvement with regards to ambulance handover times. By having the area capacity increased and the dedicated doctor based in the area, patients with a high triage priority were rapidly assessed by them and treatment could be started sooner. Although this meant reduced delays for investigations and diagnosis, it sometimes resulted in patients having to be monitored in the waiting area. Staff explained that the priority was to keep treatment areas available for higher risk patients, and so having patients waiting for results, medication or treatment in the waiting area was the only way to reduce delays. To support the safe monitoring of patients a dedicated health care assistant used portable electronic information systems which prompted them to complete timely reviews of patients vital statistics and other healthcare measures which supported the safe monitoring of patients.

We observed ED staff responding promptly to the results of investigations and referring patients for further treatment if required. However, there were often delays for specialist treatment. From the data submitted we could assess that between November 2022 and October 2023, at trust level, of the patients that had waited more than 4 hours to be admitted 53.8% had waited between 4 and 12 hours to be admitted and the remainder of the breached patients had waited more than 12 hours to be admitted.

The trust held a bed management meeting at least three times a day aimed at reducing delays for admission and assessing whether the hospital as a whole was under high levels of pressure. The nationally recognised Operational Pressures Escalation Levels (OPEL) were used to assess pressure throughout the hospital. This includes the number of beds available in the hospital and the number of patients needing to be admitted. During a meeting we attended it was reported that the hospital was at OPEL 2 which indicated that ED patients were being seen and admitted (or discharged) within four hours (meeting the four-hour standard), although with difficulty.

Urgent and emergency services

The service also monitored the number of people who left the department without being seen or receiving treatment and the number of readmissions to the department. Whilst we saw a positive trend at trust level in the number of people who left the department decreasing in the last year, we also noted that the number of readmissions had increased at this service's ED increasing from 8.3% in November 2022 to 11.3% in October 2023.

Learning from complaints and concerns

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

Patients, relatives, and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Staff told us that if a patient made a verbal complaint, they would try and resolve the concern at the time. However, they always gave patients the option of a formal written complaint.

Managers investigated complaints and identified themes. Senior ED staff sometimes phoned patients as soon as a complaint was received. This enabled them to give an early apology and to gain more details and understanding of the issues involved. Sometimes the ED was part of a wider complaint about the hospital. In such cases, a response would be sent to the patient advice and liaison service so that it could be included in a hospital-wide response. We found complaints were well investigated and a clear and courteous response was sent as part of the complaints process.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Is the service well-led?

Good ↑

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

Leadership

Leaders had the skills and abilities to run the service. They understood and were generally able to manage the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The emergency department (ED) was part of the trust's frailty, acute medicine and emergency division. The leadership of the ED was shared by a clinical group director of nursing, clinical group director and clinical group director of operations.

A local clinical lead team was allocated to the hospital with a head of nursing, general manager and clinical director. Other senior staff took the lead in specialist aspects of emergency management such as mental health, governance, service delivery and GP liaison.

Urgent and emergency services

In addition to the ED leadership team, we also interviewed the site leadership team and found that all members of the team understood the challenges faced by the service as well as the service's position within the wider hospital and healthcare system, including external integrated partners of care.

Leaders were visible in the clinical environment supporting staff, leading the treatment of the sickest patients, and dealing with the more complex situations that arose. Those that we met demonstrated the skills, knowledge, integrity, and experience needed for their roles. Staff told us that they trusted the leadership team and knew that they would be listened to if they raised concerns.

We observed constant communication between the nurse in charge and consultant in charge of the department. They jointly looked at the case notes of patients being treated as well as those who were waiting to be seen to prioritise treatment. They both frequently consulted patient information on the ED computer system in order to maintain an overview of all the patients in the department. This helped to improve patient safety and flow within the department.

Vision and Strategy

The service had a vision for what it wanted to achieve and was working on a strategy to turn it into action. The vision and strategy were focused on sustainability of services and were aligned to local plans within the wider health economy.

We found that the King George Hospital leadership teams were aligned and focused on delivering their vision and strategy for the service with patient care in mind.

The leadership team told us that their vision for the department was to deliver effective and timely care and treatment to urgent and emergency patients and their families. This vision was supported by staff that we spoke with. The vision had been shared with members of the trust board and work had started on the strategy to achieve it.

We explored how the strategy was to be delivered and were shown the service's improvement plan and informed of partnerships to deliver the service's objectives. We found these relationships to be positive and matching the specifications of the improvement plans reviewed.

Culture

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, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff in the department were cheerful, friendly, and energetic despite the sustained pressure under which they worked. They told us there were opportunities at all levels and that a supportive team of mentors encouraged career development.

Staff development was encouraged at all levels and senior staff told us they were proud of the department's ability to develop clinicians with passion for their jobs. Nurses told us they were encouraged to apply for more senior roles within the department or supported to be champions. This enabled staff to develop their clinical and leadership skills in an area where they already had a good working knowledge and support good teamworking.

Urgent and emergency services

Staff that we spoke with told us they mostly enjoyed working in the ED. They said there was a strong sense of the team being a family and a 'no blame' culture' that made it easier to admit any mistakes and to learn from them. The risk register showed that leaders were concerned about the well-being of all staff and took action to reduce threats to staff safety.

It was apparent that staff shared the same professional values. The main one being "the patient comes first". Throughout the inspection we saw this value informing the actions taken by staff. However, there was also a shared frustration that capacity problems within the hospital resulted in long delays for patients in the ED. Staff worked hard to keep patients safe but were aware that individual needs such as comfort and privacy, especially for mental health patients, were not always met.

Governance

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

Governance processes supported the delivery of effective services and were used monitor quality and safety including the management of incidents, risks, and updates to clinical practice. As an example, the Emergency Department Speciality Quality & Safety Meeting, was a monthly meeting held to update and monitor the delivery of the service. Agenda items were aligned with CQC key lines of enquiry and reviewed key governance elements such as: incident management, risk register review, clinical effectiveness such as policies, audits and reviews, workforce education and improvement plans.

Information regarding ED performance was escalated to the board monthly through the integrated performance report. This report highlighted key information, risks and challenges against key performance indicators. We reviewed the October 2023 report and found it to be informative, accurate and in line with our findings.

Mortality and morbidity reviews were well-established and were discussed monthly at a separate meeting. Lessons learned were clearly described and an action log was maintained to ensure that changes to practice were established.

There were joint governance arrangements with speciality services to monitor the effectiveness of referrals and handovers and monitor what actions could be taken to improve practice.

Governance and performance issues were discussed at staff meetings and described in the minutes.

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

The hospital held liaison meetings with senior staff from the neighbouring mental health trust. This was aimed at joint working to improve the care and safety of patients with mental illness being treated in the ED.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

We were assured that all levels of management and leadership, including the site leadership team, were fully sighted on the activity and performance in the ED.

The departmental risk register was an active document and staff at all levels made contributions to it. The ED risk register was a shared document between both hospital sites with clear indication of where the risk presented and who had accountability to managing the risk.

The risk register had risks of varying degrees described and the actions taken to reduce them were regularly reviewed. The 6 highest risks to KGH had a risk score of 16 out of 25 and above. All reflected the concerns described to us by staff during the inspection. These included risks to patients and staff due to an increase in mental health attendances and admissions, risks to the physical and mental health of staff subject to violence and aggression and risk to patient safety and staff well-being due to overcrowding in the ED.

When risks were outside the influence of ED staff, they were escalated to divisional directors and sometimes to board level.

Risks were managed and escalated to the relevant leaders depending on their priorities and scores. There were monthly meetings at divisional level to review risks and the actions and improvements to ensure that risk management was up to date. We were assured that risks of higher priority were escalated to senior managers and lower-level risks were managed and mitigated by the department's leadership team. We reviewed the October 2023 ED integrated performance report and saw how high-level risks identified in the risk register and through the service's improvement plans were correlated to the data presented to the board.

We reviewed the trust's action plan to address the findings from our previous inspection and be in compliance with regulation. The service had taken on board what our previous inspection had escalated and implemented an improvement plan to address our findings. We reviewed the compliance log and found this to be supportive of the measures taken to improve delivery of care, and also in identifying how the service was going to maintain and monitor their performance. Senior site leaders were informed and knowledgeable regarding this process as well as other performance improvement programmes.

ED staff were present at the divisional or trust performance meetings and performance data specific to the King George Hospital was easily available.

The trust had a plan for the response to major incidents such as a bus crash or major explosion.

Information Management

The service collected data and analysed it. Staff could find the data they needed in easily accessible formats. This was needed to understand performance, make decisions and improvements. The information systems were integrated and secure.

Performance data was collected regularly, and we were sure that specific ED data was used to understand performance. This included ambulance handover times, time from arrival to treatment, length of stay in the ED and time for referral to specialty.

Information from electronic patient records were easily available and reliable.

There were effective information governance processes and safeguards. Staff received information governance training and understood their responsibility to safeguard confidential data.

IT equipment, including access to electronic patient records, was protected by individual smartcards and passwords. Staff were equally careful when managing paper records.

There was a secure electronic incident reporting system in place that could be used to analyse themes and trends in reported incidents to enable reviews and appropriate mitigating actions to be taken.

Staff had access to policies and procedures via the trust secure intranet.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust engaged with staff and implemented staff surveys to inform them of how they could better support staff in their day-to-day practice, and about their challenges and opinions on how work could be improved.

There were posters in the waiting room encouraging people to give feedback and describing how to do so. The hospital's website also encouraged on-line reviews.

There were regular staff meetings to ensure that nursing and support staff were well informed and able to raise their concerns.

Discussions with staff had resulted in the creation of quiet rooms so that staff could take "time out" after stressful incidents. For example, a death in the department or violence and aggression.

The trust had appointed a patient representative to work with the newly formed clinical group. The patient representative attended a number of the clinical group meetings and was working with the Estates and Facilities Team and dieticians to ensure that the food offered in the ED met the nutritional needs of the patients. This included hot meal provision and hot snacks that are easy for patients to eat .

The ED had worked with the patient experience team to identify patients to attend a focus group that was planned to take place in the next two months. This group will help inform the development of the department vision and strategy for the coming years. They and the patient partner will help inform the redesign of the ED and the pathways that will be taking place over the next two years.

The department worked with the learning disability and dementia patient and carers groups to develop and deliver care. The trust was working in collaboration with key local partners, such as local borough councils, to create opportunities for young adults who had learning difficulties to successfully transition to work.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation.

Research from the Royal College of Emergency Medicine was discussed at governance and quality improvement meetings. It was used to inform new policies and to improve local services.

Posters in the staff room displayed learning from serious incidents.

Urgent and emergency services

The matron for the ED had implemented QR code consultation posters throughout the ED. These could be used to access policies and procedures to support the deliver of care in the department.

The service was looking forward to expanding their same day emergency care service (SDEC). They had brought consultants and specialist nurses together to discuss the next steps for this service and introduce the new SDEC.

Areas for improvement

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

MUSTS

Emergency department at King George Hospital

- The service must ensure that staff follow policy to identify and document patients who are on time critical medicines. (Regulation 12).
- The service must ensure that mandatory training is regularly updated and plans to improve compliance are implemented. (Regulation 12).
- The service must ensure that the administration of rapid tranquilisation is recorded as an incident in line with national guidance. (Regulation 17).

SHOULDS

Emergency department at King George Hospital

- The service should ensure national standards of care such as triage, handover and admission standards are met in line with legislation.
- The service should ensure that all paper patient records are labelled with patient details including allergy status are per policy.
- The service should ensure that patients who are self-administering their medications are clearly risk assessed and this is documented, and these patients are identifiable in the ED to staff.
- The service should continue to work with partner organisations to ensure mental health patients are provided with timely assessments.
- The service should continue to find solutions to minimise environmental risks to mental health patients.
- The service should continue to work on implementing a standard patient electronic record system. The system should have the capacity to integrate with other record systems such as those used for mental health patients.
- The service should update their standard operating procedures for clinical areas such as RAFT and SDEC to include all areas in the department where care is being provided.
- The service should continue to review and implement existing strategies to decrease the reliance on bank and agency staff.

Urgent and emergency services

- The service should consider further ways in which to improve privacy and dignity for all patients attending the ED.
- The service should provide all staff working in the department with name badges.
- The service should be clear to mental health patients about their admission status whilst in the department.
- The service should consider using protected time slots for all staff groups to ensure training and development opportunities are equally accessible to all staff.
- The service should remove signage that references older pathways or former service provision arrangements.

Our inspection team

We carried out an unannounced comprehensive inspection with a team comprised of a CQC inspector, a nursing specialist advisor, and a medical specialist advisor. The team were also supported by 4 specialists in the areas of medicines management and mental health care. During the inspection we spoke with 10 patients and 25 members of staff at all levels and several different disciplines. We observed patient care and reviewed internal documents and 15 sets of patient records.

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

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment