East Kent Hospitals University NHS Foundation Trust

Queen Elizabeth The Queen Mother Hospital

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
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 Queen Elizabeth The Queen Mother Hospital

Requires Improvement 

We carried out an unannounced focused inspection of the emergency department at Queen Elizabeth The Queen Mother Hospital following the 'Resilience 5 Plus' process. The 'Resilience 5 Plus' process is used to support focused inspections of urgent and emergency care services which may be under pressure due to winter demands or concerns in relation to patient flow and COVID-19.

We did not inspect any other services as this was a focused inspection in relation to urgent and emergency care. We did not enter any areas designated as high risk due to COVID-19. The inspection framework focused on five key lines of enquiry relating to critical care, infection prevention and control, patient flow, workforce and leadership and culture.

We previously inspected the emergency department at Queen Elizabeth The Queen Mother in March 2020 as part of our comprehensive inspection methodology. We rated it as Requires Improvement overall.

We spoke with 20 staff across a range of disciplines including lead nurses, senior nurses, healthcare assistants, department consultants, trust grade doctors, junior doctors, matrons, ambulance crews, the care group head of nursing, and the care group clinical director. We attended department safety huddles and a patient flow meeting.

As part of the inspection, we observed care and treatment and looked at eight care records. We analysed information about the service which was provided by the trust.

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

Urgent and emergency services

Requires Improvement 

We found:

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

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

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.

Staff completed risk assessments for each patient. They removed or minimised risks and updated the assessments. Staff mostly identified and quickly acted upon patients at risk of deterioration.

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.

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

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities. However, staff were not always clear on the process of escalation and learning from the performance of the service.

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.

However:

Not all staff had completed mandatory training. However, the service provided mandatory training in key skills including the highest level of life support training to staff.

The service did not always have enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service did not have 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.

People could not always access the service when they needed it, and it was not always timely. The department was not meeting the national four-hour performance target which meant patients could not always access emergency services when needed or receive treatment within agreed timeframes and national targets.

Urgent and emergency services

Is the service safe?

Inspected but not rated

Environment and Equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use medical equipment.

All entrances into the department were manned. The senior nurse in charge streamed walk in patients and patients arriving by ambulance. Patients were asked screening questions on arrival and had their temperatures checked.

The department had clear designated areas for the treatment and care of patients with COVID-19, in line with national guidance.

There was enough personal protective equipment available for staff and all staff wore masks and personal protective equipment correctly and in line with best practice.

There was clear signage displayed to control entry into red zones which was COVID-19 negative areas and blue zone areas which were COVID-19 positive areas. The signage clearly identified that red zones were COVID-19 negative to avoid confusion to staff and patients. Staff had a good understanding of the zoning system. Each designated area had enough specific personal protective equipment required in that zone.

There were also supporting waiting areas for immuno-compromised and shielding patients.

Patients with a confirmed diagnosis of COVID-19 were moved to an isolation area called a negative pressure room. Negative pressure rooms lower air pressure to allow outside air into the environment. This trap's and keeps potentially harmful particles within the negative pressure room preventing internal air from leaving the space, therefore protecting people outside the room from exposure.

In addition, there was a 'make-ready' room attached to the negative pressure room, where staff prepared equipment prior to entering the side-rooms. All the rooms were connected via audio and visual technology so both staff and patients did not feel isolated. This also allowed staff to communicate with colleagues for help and guidance without the need to change personal protective equipment.

Staff followed the trust's social distancing escalation process which determined if the department was becoming full. The nurse in charge was able to see this on the visual screen at the nurse in charge board area.

There were clear screens situated within all waiting areas to separate patients. All cubicles within minors, majors and resus had clear plastic curtains in the COVID-19 positive and negative areas to separate patients.

Equipment and curtains had 'I am clean' stickers to show staff they were clean and ready to use. All equipment was well maintained, and safety checked.

Urgent and emergency services

Clinical staff knew where to find the equipment they needed to respond to an emergency and had received appropriate training to enable effective use of it. Resuscitation equipment was readily available and easily accessible. The hospital had systems to ensure it was checked regularly, fully stocked, and ready for use. During our inspection, we saw staff manage a patient's care and treatment following a cardiac arrest. There was equipment available and a member of staff was used as a runner to ensure requests were met.

All store cupboards were tidy, consumables were in date, well stocked and all placed in an orderly manner.

There were two designated rooms for patients who required a mental health assessment. One met Psychiatric Liaison Accreditation Network quality standard requirements and the other was in the process of being refurbished and was not in use at the time of our inspection.

The paediatric area was currently undergoing a refurbishment. We found the area to be small and at risk of overcrowding when busy. However, during our inspection we saw staff and patients maintained social distancing.

Cleanliness, infection and control

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.

The trust had effective systems to ensure that standards of cleanliness and hygiene were maintained and offered protection and safety for staff and patients.

During the inspection, there was a sense of protection and safety for patients and staff from the entrance area, waiting room through to all staff and clinical areas.

All areas of the department were clean and cleaning schedules showed there was regular cleaning of the department throughout the day. All chairs and beds were cleaned between patients.

Staff followed the trust's infection prevention and control (IPC) policies, such as correct uniform, use of personal protective equipment and being bare elbow the elbow. We saw staff using PPE correctly and in line with current guidance.

Hand sanitisers were available throughout the department. Posters displayed in the department encouraged staff and patients to wash their hands. Hand hygiene audit results were displayed, and compliance was 99.2%. This information was available in real time on the service dashboard.

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.

Staff knew how to identify adults and children at risk of or suffering significant harm and worked with other agencies to protect them. Staff told us they were supported by the safeguarding team and able to discuss safeguarding and any concerns they had.

Urgent and emergency services

The trust had a safeguarding policy, as well as guidelines and information to support staff to recognise and manage cases of suspected domestic violence and assault. Staff knew the process of how to complete a safeguarding referral and worked closely with the safeguarding team.

We saw safeguarding pathways were used in the paediatric emergency department. All children and young people were assessed for safeguarding or concerns on arrival and a clear process of guidelines for safeguarding were in place. There was a weekly paediatric safeguarding meeting to discuss any safeguarding concerns.

The service provided staff with weekly safeguarding supervision in addition to attending safeguarding review meetings, with lessons learnt shared.

The matron or senior nurse attended frequent attender meetings with NHS ambulance and mental health trusts. The meeting was also attended by the safeguarding team. The trust had worked with a local charity, mental health trusts, GP's and police around providing safeguarding liaison support within the department.

Assessing and responding to patient risk

Staff completed risk assessments for each patient. They removed or minimised risks and updated the assessments. Staff mostly identified and quickly acted upon patients at risk of deterioration.

Patients were mostly seen within the national standard of 15 minutes on arrival to the department and came through either the main department entrance or ambulance entrance. The urgent treatment centre was based alongside the department entrance and a streaming nurse was responsible for assessing all patients attending the department.

Patients were streamed to relevant areas of the department depending on their needs. During our inspection, we saw the GP from the urgent treatment centre worked alongside the streaming nurse to triage patients and if required redirected patients to other services.

The triage nurse could order bloods and ECG's (electrocardiogram) which meant results were available when they were seen by a clinician.

Patients had access to quick and timely COVID-19 antigen tests. The service had the capacity to process these tests within a laboratory recently set up in the emergency department. Patients with a confirmed COVID-19 swabs were moved to an isolation area which had recently been converted to a negative pressure environment.

The trust had developed a rapid response team to deal with patients who required intubation and onward care in critical areas. However, the service had to remove the rapid assessment area to make way for a COVID-19 positive room. This meant there was no rapid assessment process in place which led to delays in treatment times and a lack of initial senior review. The service had plans in place to reintroduce the rapid assessment area in the redesign of the department. The development of the urgent treatment centres in the department helped the department manage the demand of triaging patients.

We found nursing assessments for skin integrity and falls risk were completed and re-assessed when a patient's condition changed or at set intervals. For example, we saw a patient be reassessed for redness to the skin. A specific pressure relieving mattress was brought down to the department for the patient to lay on whilst waiting transfer to the ward. This helped to prevent pressure damage.

Urgent and emergency services

Staff used national tools for assessing risks and were trained in managing emergencies appropriately.

Patient observations were recorded, and staff used a national early warning score (NEWS) tool. NEWS is a simple, physiological score that may allow improvement in the quality and safety of management provided to patients. The primary purpose is to prevent delay in intervention or transfer of critically ill patients. Observations and NEWS scores were displayed on the trust's electronic system at the nursing station, so staff were able to observe patients at risk of deterioration.

However, some staff told us the electronic observation system in the department did not easily highlight/identify trends in patient's observations to staff. The department had plans to move onto a different live system which it hoped would make identifying deteriorating observations clearer.

We found all patients in majors were continuously monitored for observations, the results were not always entered or recorded on an hourly basis but if not were documented two hourly. For critically ill paediatric patients, the clinical leads had decided to continue to use paper paediatric early warning score (PEWS) charts instead of the electronic observation system.

The electronic dashboard displayed at the nurse in charge station showed clearly where patients were on their patient journey, who was looking after them and their NEWS score.

A hospital ambulance liaison officer was available in the department to oversee ambulance queuing. The trust had a policy of not queueing ambulance patients in corridors or within the department due to risk of COVID-19. Instead they would keep patients in the back of ambulances for assessment, entering patients onto the IT system and actively reviewing and treating the patient unless the patient was a priority. We spoke to both paramedics and other ambulance staff who were complimentary about the responsiveness of the emergency team about patients they had conveyed to the ED.

Staff could describe the process for the management of sepsis. Clinical guidelines supported staff in managing sepsis. The guidelines were accessible from the trust intranet and the emergency department mobile app.

The inspection team saw a cardiac resuscitation take place within a negative pressure room. The room was linked with CCTV and audio so that staff in the negative pressure room could be well supported by staff outside the room. All nursing and medical staff were in full personal protective equipment. Staff adhered to the maximum room capacity. A runner provided any support and equipment if needed. The process ran smoothly and well.

The department saw a rise in the number of mental health patients attending the department since the start of the pandemic. This had raised concerns with staff around having enough of the right support available for mental health patients such as a regular mental health nurse, timely psychiatric assessment and enough department security.

Staff had escalated this to the executive team and senior leadership were encouraged to complete an electronic incident reporting form if they felt they were unable to access the right mental health support for the patient. Staff told us they were supported to book mental health nurse to cover shifts and support workers had undertaken training in mental health.

A yellow and red card system was in place for disruptive or abusive patients. The matron told us they took the safety of their staff seriously.

Urgent and emergency services

Since the first wave of the pandemic, the department had increased security and staff told us they felt more supported and safer. There was a joint working group which included a local mental health trust and senior leaders from the department. Staff had access to an alcohol misuse team and there was a joint substance misuse pathway in place.

Children needing mental health support were immediately admitted to the children's ward.

Nursing staffing

The service did not always have 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.

Nursing staff had completed the trust target for five out of the nine nursing modules and paediatric nursing and admin staff met all their mandatory training targets. We were told that since the pandemic, it was not always possible for nursing staff to keep up to date with training.

Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. However, the department found it difficult to recruit due to its location and there were higher than usual levels of staff sickness caused by the pandemic.

During the second wave of the pandemic, the hospital had to take staff from other areas to work within the department due to staff sickness. We were told by senior staff that some of these staff chose to remain working within the emergency department.

Some staff returning to work from shielding due to the coronavirus were given non-clinical and administrative tasks on their return.

A daily staffing call took place with the workforce director to review staffing and any shortfalls within the rota. The hospital worked well with other trust sites to support staffing levels. The trust paid staff taxis to enable staff from neighbouring trust sites to work at the hospital. The trust had also increased the bank rate payment as an incentive for staff.

Senior staff told us that they had raised staffing concerns to the executive team, as well as ideas on how to promote working for the trust. However, staff were not aware of how the trust were currently looking to recruit more staff.

On the day of our inspection, the department was adequately staffed with clinical and non-clinical staff during the day including a mental health nurse. The evening shift was not fully staffed. However, the senior team liaised with the other sites and confirmed that two members of nursing staff would cover the shift. Staff told us that this happened often but staff from each site worked well together and were generally happy to work cross site when required.

Medical staffing

The service did not have 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. However, managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

Urgent and emergency services

The department had just four full time equivalent consultants, this did not meet the recommendations of the Royal College of Emergency Medicine guidelines of consultant cover within the department. The service did, however, have 28 middle grade doctors recruited to the department.

The department provided two days of emergency department teaching per month for middle grade doctors. This was felt to work well and was less disruptive to service provision. However, not all medical staff had completed their mandatory training. With only one out of the eight modules of mandatory training being met. This was children's safeguarding level 2, which was 100%.

The executive team told us they were aware of the shortage of consultants within the department of the hospital and were working with specialists within recruitment to develop a work force plan.

The trust mitigated the risk of medical staffing by utilising consultants' cross site to provide support and additional medical cover as well as regular locum doctors. Medical and orthopaedic doctors would also support the department with triaging medical patients.

We found that although the department did not have enough medical staff, it had medical cover between 8am and 10pm daily.

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.

Patients were clerked onto a new electronic system. All staff had access to this system and could update.

We reviewed eight sets of notes from unwell patients in majors and resus. These notes were appropriate with clear action plans and observations. Patients who were discharged had clear and appropriately formatted letters sent to their GPs. GP letters included appropriate clinical documentation, copies of all blood results and pathology results and any changes to medication. Staff told us these systems had recently been improved after several complaints from local GPs and the process was working well.

Is the service responsive?

Inspected but not rated

Access and flow

People could not always access the service when they needed it, and it was not always timely. The department was not meeting the national four-hour performance target which meant patients could not always access emergency services when needed or receive treatment within agreed timeframes and national targets.

The department used a flow coordinator to help with the onward movement within the department using an electronic medical recording system. The flow co-ordinator managed patient's results and ordered diagnostic tests. The department on average saw 200 to 300 patients a day.

Urgent and emergency services

We found the nurse in charge had a good knowledge of what was happening within the different areas of the department and responded well to ambulance arrivals whilst allocating staff to the correct areas. Patients were streamed both at the front door for walk-in patients and by the duty sister or charge nurse for ambulance arrivals. Triage staff used an emergency severity index system and this was clearly documented on the whiteboard. The emergency severity index is a five-level ED triage system.

The GP from the urgent treatment centre was based within the department. The urgent treatment centre received referrals from a direct access booking service and the department.

We were told the department followed national guidance on the care and treatment of patients in emergency settings and there was a strict policy of not queuing or cohorting patients in corridors. We saw no overcrowding or patients being looked after in corridors during our inspection.

Staff undertook two hourly patient board rounds. We saw one of these board rounds in which senior multidisciplinary staff discussed every patient in the department and reviewed their clinical management plan. There were clear plans for escalation.

The department had a good relationship with acute medicine and other specialties. When times to assess patients increased and flow in and out of the department was affected, specialty doctors reviewed patients within the department.

Advanced warning was given if a COVID-19 positive patient was due to arrive by ambulance. On arrival, the patient was immediately transferred into the negative pressure room. staff told us this worked well.

Patient flow out of the department was monitored throughout the day in the morning huddle, winter room meeting and at the 5pm site meeting. Trust data showed 66.2% of patients in January 2021 and 74.5% of patients in February 2021, spent less than four hours in department. This was worse than the England average of 76.8%.

Trust data showed 40.9% of patients in January 2021 and 37.09% of patients in February 2021, waited 60 minutes or less to be seen by a doctor or clinical professional.

Senior staff told us that losing the rapid assessment area during the pandemic, winter pressures and higher volume of patients during the pandemic has led to higher waiting times for assessment.

The departments did not meet the 5% national reattendance rate for patients reattending the emergency department within seven days of their original visit. The trust reattendance rate was 12.1% in December 2020, 11.2% in January 2021 and 11.1% in February 2021.

Trust data showed 40.9% of ambulance handovers in January 2021 and 37.09% of ambulance handovers in February 2021, took place within the 15 minute triage national standard.

The trust recorded on the key performance indicators the number of times ten ambulances or more arrived to the emergency department site within an hour. This information showed the department how frequently clusters of ambulances were arriving to the department and the potential to add additional pressure onto the front door in terms of timely handovers and assessment of arrivals.

Urgent and emergency services

Data showed one cluster of ten ambulances or more arrived at one time in January 2021 and six within February 2021. The performance data above for February showed that the high numbers of ambulances attending the department could have impacted on the times patients waited to be seen by a clinician.

On the day of our inspection, the department had been quieter than usual in the morning. However, by the 5pm site meeting the department was busy and had waits for up to 58 minutes for assessment and seven ambulances waiting. We saw the senior leadership team communicated between locations and requested medical teams to review specific patients to allow the ED doctors to triage and treat. This process worked smoothly and well.

Is the service well-led?

Inspected but not rated

Leadership

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

The department had a dedicated leadership team who were responsive to the needs of patients, developing staff and improving safety.

The department was managed by the urgent and emergency care group. The group was overseen by a clinical director who was relatively new in post. They held the responsibility for both the William Harvey Hospital and Queen Elizabeth, The Queen Mother Hospital sites with the clinical lead specifically based at the Queen Elizabeth The Queen Mother site. Their key priorities were to improve flow in the departments and the recruitment of senior consultants to support decision-making and development.

The senior leadership team consisted of a interim head of clinical operations, a head of nursing and a lead consultant for both trust sites. There was a deputy head of nursing, an urgent treatment centre matron for both trust sites and matron for the emergency department, Queen Elizabeth The Queen Mother Hospital. The team had vacant posts to be filled for a second deputy head of nursing and two acute nurse consultants.

Leaders we spoke to were aware of the day to day challenges staff faced during the pandemic and throughout the winter pressures and were keen to improve recruitment and the department to work better for staff and patients.

Staff spoke highly of the senior leadership and described them as approachable, knowledgeable and supportive. Staff felt confident in their leadership and valued.

We were told the executive team listened and there had been a number of improvements made to the department since our last inspection to reduce the risk and spread of COVID-19 to staff and patients such as specified areas for COVID-19 patients with negative pressure rooms in place.

Culture within the service

Urgent and emergency services

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 were friendly and caring towards patients and to each other. Staff were happy to talk to the inspection team and wanted to tell us why they enjoyed working in the department. There were good working relationships with specialties and the staff worked together as a team to promote good patient care.

We spoke to a variety staff including junior doctors, healthcare assistants, junior nursing staff and the flow coordinators. All the staff were very complimentary about the senior leadership team and each other. Several staff from the department and acute medical unit told as they would be confident if their own relatives were treated in the department. There was clearly a helpful, positive and caring culture within the department.

Managing risks, issues and performance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities. However, staff were not always clear on the process of escalation and learning from the performance of the service.

During our inspection, we saw there was a clear governance structure. The department held a monthly emergency governance and patient safety meeting. Information and updates from the urgent and emergency care group fed into the executive team governance.

The governance meetings included governance updates, trends and themes, serious incidents, audits, updates from the mortality and morbidity group as well as current audits and care pathways.

Teaching sessions for nursing and medical department staff were on a Friday each week. The sessions provided learning on serious incidents and lessons learned.

The department, alongside the practice development clinical facilitator, had put together a specific emergency department course for all staff, and all staff were encouraged to attend.

The department had their own key performance indicators for appraisals, reattendance rates, waits in observation ward and persisting medical errors. The trust failed to meet some performance indicators due to the pandemic.

There was a new integrated IT system in the department which meant patient notes were clearly visible in all areas of the department. However, alongside this new system an older dashboard continued to be in use which included blood results flashing onto the screen to attract the attention of the staff as well as automatic and updated NEWS scores. There was a plan at some point to add this dashboard onto the new system. Staff did not find using the two systems alongside each other an issue.

During our inspection, we reviewed a comprehensive escalation policy and full capacity protocol. However, it was not clear whether staff fully understood the policy and whether the actions were embedded within the service. We found staff not fully aware of the OPEL (operations pressure escalation level) level the department was currently operating at. The OPEL framework provides clear expectations around roles and responsibilities for all staff involved in escalation in response to pressures within the hospital.

Urgent and emergency services

Senior staff told us that during the pandemic, and at peak times, the OPEL level declared did not always reflect the demands placed on the service at that time. However, this had been escalated to the executive team.

There was a system to share key information with staff using an easily accessible application on staff mobile phones. This included current guidelines, care pathways, well-being and educational messages.

National safety alerts and changes to Royal College of Emergency Medicine (RCEM) are shared with staff via the emergency department app and the clinician and nursing mobile phone groups. Medical staff were added to the department app as part of their induction process to ensure they had access to all current department and trust guidelines.

There was a monthly risk and governance group who review current changes within practice or new guidelines. The emergency department clinical audit lead attends the clinical audit and effectiveness committee and fed back specific guidance to department leads.

Areas for improvement

SHOULDS

- The trust should meet the Royal College of Emergency Medicine requirements for the number of consultants employed within the department.
- The trust should ensure they improve their four-hour performance targets.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and two specialist advisors. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.