Medway NHS Foundation Trust

Medway Maritime 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?	**Inadequate**

Our findings

Overall summary of services at Medway Maritime Hospital

Requires Improvement 

We found:

- Staff did not always keep detailed records of patients' care and treatment when completing records for urgent and emergency care patients. This included the completion of nursing, falls and skin risk assessments.
- Care for patients showing signs of deteriorating were not consistently escalated placing patients at risk.
- The department did not always control infection risk well increasing the risk of cross infection.
- There was poor flow out of the department, patients experienced substantial delays before being admitted or discharged.
- The leadership, governance and culture did not always support the delivery of high-quality person-centred care for patients.

However:

- The service had suitable equipment which was easy to access and ready for use.
- Generally, staff told us they enjoyed working in the department and spoke of positive working relationships within the team.
- Patients had access to a psychiatric liaison 24 hours a day. Staff told us although the team were increasingly busy, they were responsive and would see patients within two hours or initial referral.

Urgent and emergency services

Inadequate 

We carried out an unannounced focused inspection of urgent and emergency care provided by this trust on 14 December 2020. This was in response to continued concerns of poor performance in meeting national targets and affecting patient's safety. The service was rated required improvement at our last inspection in December 2019.

Our rating of the service went down. We rated urgent and emergency care as inadequate.

- During the inspection, we spoke with over 15 members of staff, from various disciplines and the leadership team for the department. We reviewed six sets of patient records.
- To help maintain patient and staff safety during the COVID-19 restrictions, we followed all relevant guidance and visited selected areas of the department only.

How we carried out the inspection

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.

Is the service safe?

Inadequate 

Assessing and responding to patient risk

Staff did not consistently complete risk assessments for each patient swiftly. They did not minimise risks and updated the assessments. Staff did not identify or quickly acted upon patients at risk of deterioration.

Patients arrived in the department through the main entrance or the ambulance entrance. The main entrance had a streaming nurse responsible for assessing all patients for risk and for COVID-19 symptoms before streaming (directing) them to the relevant areas of the department depending on their needs. The ambulance entrance had an ambulance control nurse, who took handover of patients from ambulance staff.

Staff told us they used local knowledge or their own judgement to assess patients. Similarly, in the children's emergency department, staff said they did not use a streaming tool to assess patients. We raised this as a concern with the managers who said there was a risk stratification tool used. We were told 43 members of staff had completed the initial assessment skills- prioritisation and patient management competencies. During our inspection we found staff were unable to demonstrate and were not aware of a standardised risk stratification tool to ensure consistency of care for patients arriving in the department.

The department used the national early warning system (NEWS) for adults and the paediatric observation priority score for children. The scoring systems enabled staff to identify patients who were becoming increasing unwell, to provide them with increased support and improve patient outcomes.

The trust had a standard operating procedure for recognising and responding to unwell patients which was last reviewed in September 2019. The guidance advised staff to monitor patients at least every 12 hours, however the

frequency could be increased as stated by the early warning score escalation process or as advised by the consultant. We reviewed six patient care records and found although the national early warning system scores had been calculated accurately and repeated at various intervals, high NEWS scores were not escalated in a timely manner. For example, in one patient's notes we saw NEWS scores of six, nine and nine recorded at different intervals, yet there was no further documentation of increased care or escalation.

At peak times staff said offloading ambulance patients compromised patient care. Due to the demand, medical and nursing staff were not able to ensure patients waiting in the ambulances always received timely clinical intervention. We observed one patient who had been waiting on an ambulance with a NEWS score above 7. We highlighted this to the streaming staff who immediately acted to escalate and admit the patient into the emergency department.

The trust provided us with a sepsis audit from April 2020. There were no further recordings of performance from April 2020 to the time of our inspection, therefore we were not assured the department was consistently recording and monitoring their performance to support clinical decision making and patient safety.

Not all nursing risk assessments were completed. Records reviewed showed incomplete documentation for skin and falls assessments. This was a risk, especially for patients who were admitted with a fall or were frail with an increased risk of skin damage.

We reviewed the urgent and emergency care group governance board report for October and November 2020. All patients that had fallen during their time in the department were reviewed by a member of the falls team. Themes from these reviews include neurological observations not being completed in line with NICE guidelines, partially completed post falls checklist and lying/standing blood pressure not completed.

Records

Records of patient care and treatment were not kept up to date and did not contain all the information required.

The emergency department carried out a departmental documentation audit twice a month which showed the department was performing well against the standards. For example, out of the 9296 attendances in November 2020, 100% of patients received a pain assessment, had a plan of care documented at initial assessment and safeguarding information completed.

However, on the day of our inspection we saw patient care records were not completed. We reviewed six patient records and could not determine what care was being provided to patients in emergency department due to the lack of complete documentation. Patient risk assessments were not always completed or there were minimal care entries. In four of the six patient records we found skin integrity, patient repositioning and/or falls assessments had not been completed. Some patient records were not updated to state the outcome of diagnostic tests.

This was raised with the trust leaders and following the inspection the trust provided us with their action plan to address this concern. The trust told us nursing staff were to be informed of the standards for undertaking and recording clinical observations at each handover and reinforced via email and staff meeting's until embedded in practice. The department were to carry out daily audits to assess compliance with documentation.

Environment and equipment

Urgent and emergency services

The service had suitable equipment which was easy to access. However, staff were not always supported by the environment to protect their patient and themselves from infections.

During our inspection the main emergency department was undergoing building works and the paediatric emergency department had been moved to a ward next to the children's ward due to the Covid-19 pandemic.

National guidance recommends designated areas for the treatment and care of patients with Covid-19 should have signage displayed warning of the segregated area to control entry. The department had created hot, cold and warm pathways in response to the COVID-19 pandemic. Areas were clearly marked to identify which pathway they were in. Staff had a good understanding of the zoning system and the level of personal protective equipment required for each zone. The hot pathway was for patients who tested positive for COVID-19. The cold pathway was for patients who did not exhibit COVID-19 symptoms. The 'warm' pathway was for those patients with symptoms associated with COVID-19 but had not had this confirmed or were waiting for a COVID-19 test result. This pathway was also used in the paediatric emergency department where children with symptoms normally associated with the winter months but had not had a COVID test or were waiting for their Covid-19 test results were looked after. Staff told us rapid testing for Covid-19 had begun recently however, only three tests could be completed per hour with an average wait for results of four hours. This increased the risk of non COVID-19 patients being exposed to the virus.

In the main emergency department, there were two entrances into the department, one for ambulances and the other for patients walking in. There was a one-way system for entering and exiting the main reception however, once in the department there was no segregation of traffic. We also noted patients exiting through the entrance. Staff told us this was not well policed, and they relied on the posters displayed throughout the department to remind visitors on how to exit the building.

The children's emergency department which based in a ward, did not have a one-way system of traffic flow because of the environment. Corridors were too narrow to allow for adequate social distancing. We saw a hot toilet for Covid-19 patients in a cold area increasing the risk of exposure to infection.

National guidance recommended emergency departments should map patient journeys both within and outside of the department to determine likelihood of cross contamination and any need for additional precautions. There should be practical measures to control people's movement within the emergency department (patients, visiting team etc.) and where possible, try to ensure patients with and without infections, visitors and suppliers take different routes.

There was signage throughout the department reminding people to keep a safe distance.

We did not see any signs in non-clinical areas such as offices and storage rooms or staff rooms to indicate the maximum capacity of that room. This meant staff did not always know how many people could be in a room at any one time to safely maintain social distancing. Following the inspection, the trust told us the health and safety, and PPE officers would revisit clinical areas to check signs in offices and rest rooms.

There were two side rooms in resus for aerosol generating procedures. These were staffed by dedicated nurses for aerosol generating procedures to prevent staff from moving between hot and cold pathways.

Cleanliness, infection control and hygiene

The environment was generally clean and dirt free. Cleaning wipes were available throughout the department.

Urgent and emergency services

Various areas in the department changed from hot areas to cold areas depending on the number of COVID-19 positive patients present in the department. Staff reported hot areas were deep cleaned before changing to cold areas. We spoke to a member of the housekeeping staff who was responsible for cleaning to the department. They told us they there were usually two housekeepers in the department throughout that day, but this had not been the case recently. They explained that when an urgent deep clean was required they escalated concerns and received timely support from the trust's response team.

Staff and patients had access to enough hand decontamination gel or handwashing facilities within the emergency department. We saw hand gel dispensers were available at key points throughout the department for patients, staff and visitors to use. For example, there was a hand gel dispenser when entering the department, at the reception desk and as you moved from one area of the department to another. We saw staff using these throughout our inspection.

As well as traditional sinks, the department had portable handwashing facilities in corridors and the reception area to enable staff and visitors to wash their hands with easy access. All sinks had signs to prompt staff and inform patients of the correct steps for effective handwashing.

All staff we observed during the inspection were 'bare below the elbows' and dressed in accordance with trust policy. We saw ample supplies of personal protective equipment such as aprons, gloves and face masks and we saw these items being used. Gloves, in the full range of sizes, and various types face masks were readily available. Staff had convenient access to the correct personal protective equipment to keep themselves and their patients safe.

Personal protective equipment (PPE) such as disposable aprons, eye protection, face masks and gloves were easily accessible for staff. We observed staff wearing them when delivering personal care.

Staff had access to the updated donning (putting on) and doffing (removing) guidance on the trust intranet which also directed them to the latest national guidance on the government's website. Managers told us when changes were made, this was communicated to staff through the intranet, a mobile messaging application and information was placed in staff rooms. However, the trust did not provide us with evidence of how they monitored that staff had read and understood refreshed guidance.

We noted that donning and doffing stations were clearly marked out. Prompts on how to put on and remove PPE were displayed directly above the stations for staff to follow. The prompts were tailored to the area staff were about to enter or exit for example, there was a poster for putting on PPE when entering and exiting an area dedicated to aerosol generating procedures.

Staff were observed donning and doffing personal protective equipment. However, this was not always consistently done in line with national guidance. Staff did not always change PPE when entering and exiting patient bays. For example, in the children's emergency department we saw a registrar exiting a hot area wearing their full PPE to speak to a nurse in the main corridor. This was not in line with the trust policy and was in line with findings reported in the urgent and emergency care group governance board report for November and December 2020. Key findings from both reports for the infection control audit stated staff were not using PPE in line with the policy. Staff did not remove gloves and aprons when leaving the point of care and staff were not compliant with donning and doffing.

We raised concerns around the safety of having donning stations within busy corridors of the department used by staff and staff transferring both COVID-19 and non COVID-19 patients. Trust leaders told us an IPC advisor had been to the department to review the donning and doffing areas and remind staff to doff PPE before leaving the hot area.

We checked various pieces of equipment and furniture including chairs and ECG machines. These all appeared clean and dust free. The department made use of 'I am clean' stickers to ensure staff knew that equipment was clean and ready for use. However, we noted most stickers had been placed in the morning and had not been updated throughout the day and after use. Stickers are a useful indication of the date and time the article was cleaned along with the name of the person who cleaned it. More consistent and frequent use of these stickers would help staff to identify items that were cleaned and ready for use and assist managers in detecting any shortfalls in equipment hygiene. Following our inspection, trust leaders told us all staff had been reminded of the importance of cleaning equipment between patients. Additional housekeeping staff had been identified to attend emergency department, to regularly clean furniture and equipment This was to be monitored through quality assurance visits.

Nursing staffing

The service did not have enough nursing and support staff available with the right qualifications, skills, training and experience to provide the right care and treatment.

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, due to high levels of staff sickness caused in the main by the coronavirus pandemic, it was increasingly difficult to ensure all shifts were filled. Nursing fill rates reviewed for 1 December to 14 December 2020 showed staffing deficits on most days. Managers told us they were often three or four qualified nursing staff short on each shift.

On the day of our inspection we saw that the actual count of nursing staff in the emergency department did not match the planned staffing count. Safe staffing levels for the whole day required 39 registered staff however, 31 staff were available. Similarly, the planned unregistered staffing was 19 compared to an actual count of 12. The department was supported by emergency nurse practitioners whose shifts were staggered throughout the day. Data showed the department had four emergency nurse practitioners rostered throughout the day which was one practitioner less than planned.

In the children's emergency department data showed 98% of registered nursing shifts and 100% of unregistered nursing shifts were filled. On the day of our inspection data showed there were enough registered and unregistered nursing staff during the day. The night shift had one less paediatric nurse than planned. Staff told us due to the proximity to the children's ward, they received supported from the ward if they required more staffing.

All nursing staff in the children's emergency department were registered children's nurses. This was in line with guidance set out in the Royal College of Paediatrics and Child Care: Facing the Future: Standards for Children in Emergency Care Settings.

Managers regularly reviewed and adjusted staffing levels and skill mix where able. Emergency department staffing levels were under scrutiny at various meetings held throughout the day including at regular site meetings and trust-wide huddles. The workforce resourcing manager and the 'safe care wheel' provided intelligence about staffing and acuity that was shared directorate wide. Sickness data revealed high numbers of staff were absent due to stress and anxiety. Staff told us there were times when sourcing extra staff was difficult. It was believed people were struggling with the demands of the work in the pressurised emergency department. Managers tried to fill shifts using bank staff, offering extra hours and by deploying specialist nurses or those with clinical skills employed in other roles to the frontline.

In the last 12 months the trust reported an average sickness rate of 3% for nursing staff in the both the emergency department and the children's emergency department. Around the period of our inspection (1 December 2020 to 18

December 2020) the trust reported a sickness rate of 7% in the emergency department for nurses, and 6% for paediatric nurses compared to the trust target of 4%. Managers told us although the sickness rate was currently higher than they would like, it was more manageable compared to September 2020 when the sickness a sickness rate had risen to 36% for nursing staff in the main emergency department.

Medical staffing

The service did not have had enough medical staff with the right qualifications, skills, training and experience.

At our last inspection, the emergency department did not meet the recommendations of the Royal College of Emergency Medicine guidelines of consultant cover within the department. This was still the same at this inspection. The recommendations state consultant cover must be provided a minimum of 16 hours a day. Where there is an insufficient number of consultants to meet this, risks should be mitigated by the provision of senior doctor (ST4 or above) presence 24 hours a day, seven days per week. During our inspection, we found consultants in the emergency department provided 15.5 hours of cover a day which was lower than recommended. However senior doctors were available 24 hours a day.

Rotas provided by the trust for the week of our inspection (14 to 20 December 2020) showed that there was a consultant rostered to provide on call cover. On call cover consisted of 7.5 hours on site and a further 7.5 hours remote cover.

During the week of our inspection consultant cover for the children's emergency department did not meet national guidance. Consultant cover averaged four hours during daytime and on 16 December there was no consultant cover for the day. Data showed there was one foundation year two doctor who provided cover for children's emergency department and the minors area between 8am and 5pm with support from the on-call doctor.

Data submitted by the trust showed eight out of 19 consultant shifts between 1 December and 14 December 2020 were covered by on call doctors, with 37% (seven) of these consultants being bank staff. During the same period data. Medical staffing was worst affected on nights and at weekends.

From 1 December 2020 to 14 December 2020 data showed 71% of shifts in the emergency department were filled and 18% of these were filled by bank staff. Data showed of the 29% of medical shifts that were unfilled, only 3% were offered to and covered by bank staff. In the children's emergency department 75% of medical shifts were filled and 25% were covered by bank staff. The department did not use any locum staff during this period.

From 1 December 2020 to 18 December 2020, the trust reported a sickness rate of 1% for medical staff and the average sickness rate for the last 12 months was 2%. This was lower than the trust target of 4%.

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff and made sure everyone completed it.

The trust provided staff with a mandatory training programme. Compliance was recorded and monitored using a computerised system maintained by the trust.

Urgent and emergency services

Subjects covered included child and adult safeguarding, information governance and data security, infection prevention and control, health, safety and welfare and equality diversity and human right. Some training topics were offered 'on-line' through an internet-based learning management system, which could be accessed by staff from any computer connected to the internet.

Staff we interviewed said they received training to ensure they had the skills to do their jobs. Staff reported having adequate time allowed to completed training and attend trust courses.

The trust set a target of 85% for completion of mandatory training. At the time of our inspection compliance for mandatory training for administrative and medical staff met the trust target with a completion rate of 85% and 89% respectively. Nursing staff were shy of meeting the target with a completion rate of 84%.

However, all staff groups including medical, nursing and administrative staff did not meet the trust training target of 85% for resuscitation in adult basic and immediate life support, new born basic life support and paediatric basic life support. Compliance varied from 55% to 79%.

Is the service responsive?

Inadequate 

Access and flow

People could generally access the service when they needed it, although this was not always timely.

The nurse in charge was responsible for managing flow in the emergency department with the support of an emergency physician in charge. Patient flow out of the department was monitored though three daily site meetings.

At the last inspection in December 2019, we found adult patients experienced significant delays whilst waiting to be admitted, which was consistent with our findings during this inspection. We found decisions of onward care were not made in a timely way or there were lengthy delays once a decision to admit had been made.

For example, one patient had arrived in the emergency department at 10.30am with chest pains and was still in the department at 7pm without a decision of onward care.

Another patient had attended emergency department at 4.37am and was still in the department at 18.55pm. A decision to admit had been made in the morning but the patient was still in the emergency department eight hours later.

We saw one patient who was intubated and remained in the department for 24-hours. A decision for onward care into an appropriate care setting, where the patient could be cared for by staff with the relevant skills had not being made.

We spoke with one patient who was brought in by ambulance the night before our inspection following an episode of paranoia. The patient had been reviewed by the psychiatric liaison within two hours of initial referral. As onward care

provisions were being arranged, staff had placed the patient in the dedicated mental health room but would move them into the empty clinical decision unit when the patient became agitated due to the lengthy wait. Staff indicated the waiting time for a crisis bed and travel arrangements to be made for mental health patients took between two hours to three days.

Staff told us there were frequent closures of assessment areas, often due to staff shortages which contributed to increased delays in the emergency department. Managers told us surgical assessment unit was frequently blocked and at the time of the inspection, the clinical decision unit was taking no patients due to a lack of staff.

Patients arriving by ambulance were assessed immediately and had an initial assessment completed. Evidence received from the trust of the November 2020 departmental documentation audit showed patients arriving by ambulance waited on average three minutes before having an initial assessment while those walking in, waited seven minutes to have an initial assessment.

However, due to lack capacity in the emergency department, ambulance patients were left in the care of ambulance staff. On the day of our inspection, the department reported 24, 60-minute handover breaches. The highest ambulance handover delay was 7 hours and 40 minutes.

We spoke with four ambulance crews waiting to handover patients who said they often felt vulnerable caring for elderly and frail patients for extended periods which caused patients to become distressed. They also voiced their frustrations of having to extend their shifts while waiting to handover, which impacted their rest periods between shifts.

At the time of our inspection the average time between a decision to admit and admission was 8 hours and 45 minutes.

From 1 December 2020 to 14 December 2020, an average of 202 patients attended the department per day. On the day of our inspection between 12pm and 9pm, there was an average of 62 patients an hour in the department.

From 1 December 2020 to 14 December 2020, 635 patients experienced delayed decision to admit and a further 264 patients waited over six hours for a bed to be available. In the same period 62 patients waited over 12 hours in emergency department.

From June 2020 to December 2020, the emergency department reported 166 incidents of 12-hour breaches from decision to admit as part of their serious incidents. The department acknowledged there were lessons to be learnt from incidents of 12-hour breaches.

We raised concerns about the substantial emergency department waits. The trust leaders provided us with an action plan of changes they were to implement to improve this. Actions included but were not limited to; immediate escalation to the nurse in charge of any patients not seen by a specialist team within one hour, effective bed management meetings with escalation of any emergency department delays with executive director leadership and oversight and re-introducing planned care divisional leadership team to the surgical pathway co-ordinator post to facilitate a speedier transfer of patients out of the department.

There were a variety of pathways to enable patient flow, including same day emergency care for non-frail acute medicine, surgical assessment unit, gynaecology assessment unit, and a primary care service, depending on the need to reduce admissions and support earlier discharges.

Urgent and emergency services

Patients were able to book an appointment in the emergency department and same day emergency care through a direct access booking service. However, managers told us this service had been launched a few weeks before our inspection and was currently underutilised. Other initiatives were being developed or soon to be introduced such as the frailty pathway to reduce all emergency department attendance.

Is the service well-led?

Inadequate 

Leadership

There was a triumvirate leadership team consisting of a general manager, a head of nursing and an emergency department consultant.

Leaders generally understood the challenges the department faced and made attempts to address these difficulties. Staff spoke highly of the local leadership and described them as approachable, knowledgeable and supportive.

Most staff told us they did not feel the executive team supported the department to make improvements to reduce the impact of risk. They said concerns escalated to the executive team were not routinely discussed at strategic meetings and were not acted upon in a timely way.

Staff told us the chief operating officer and chief nursing and quality officer were visible in the department, but they felt disappointed with the lack of presence of other executive members especially during a pandemic.

Culture within the service

Staff and managers, we spoke with told us morale in the department was very low and lower than at our last inspection in December 2019. The main issues attributed to the low morale were, not enough staff to provide sufficiently timed care to the number of patients attending the service, feeling unsupported by other departments and the executive team. We were told the escalation of concerns was not listened to or acted upon.

Managers told us the chief executive and chief operating officer had held three Q&A sessions with the department to engage with staff. These sessions were poorly attended and at one of the meetings the executive team did not attend.

We attended a site meeting on the day of our inspection where we observed impolite and unsupportive challenges between attendees. The emergency department managers told us such interactions had greatly affected senior staff who now refused to attend the meetings.

Staff shared with the inspection team an email they had received from a member of the executive team following a couple of incidents. We spoke with nine members of staff of all levels, who told us the email was personally addressed to each staff member in the department. They said the tone and content of the email had contributed to the team's low morale and came at a time when staff were already feeling the pressures of Covid-19. Staff said they did not feel valued and felt their efforts through the pandemic were not recognised by the executive team.

Urgent and emergency services

Staff told us they tried to boost morale within the department by holding activities and events such as a bake off and advent calendar raffles. Staff within the department spoke of positive working relationship with their colleagues and managers and described themselves as having a strong team unit. Staff felt they were respected and valued by their local managers. Staff were positive about their roles.

Following our inspection, we had a meeting with the freedom to speak up guardian who told us there were recurring concerns around poor culture within the emergency department.

Governance, risk management and quality measurement

There was a lack of clear and consistent governance arrangements in place. The arrangements were not adequate to ensure high standards of care and oversight could be maintained.

During our inspection we noted there was no clear governance structure. The managers told us governance meetings lacked consistency. We were told many processes had stopped due to Covid-19. For example, the monthly care group meeting was last held in October 2020.

We raised the lack of a robust governance structure as a concern to the trust leads, who told us a review of the process was being carried out and they planned to reinstate the care group governance meetings as of 4 January 2021.

The department was not assured they were robustly assessing and mitigating the risks relating to the health and safety and welfare of patients. Managers were able to describe the three biggest risks to the department. However, the team did not include recurring delayed handovers of patients from ambulance crews as one of their biggest risks. Although they were aware of the issue, there did not appear to take ownership of the risk or have a system to mitigate it.

The trust held three site meetings a day, attended by representatives from various departments including but not limited to surgery, planned care, emergency department and diagnostic imaging. We observed a virtual site meeting at 4.30pm and were concerned about the lack of action taken particularly for patients who had been in the department for more than 12 hours. Furthermore, the meeting lacked order and structure. We noted actions from earlier meetings were not reviewed for progress. We witnessed a lack of accountability to provide patients with the necessary care and environment conducive to better patient outcomes.

The department had an emergency department quality and safety daily checklist used to record concerns throughout the day. It was not clear what purpose the quality and safety checklist served. The logbook had numerous entries of general and quality issues. We noted there were escalation of concerns to the site team however, it was unclear how often these were reviewed by senior staff, if escalations had been acknowledged or whether any action had been taken to mitigate risks.

The department held regular huddles which included governance updates. We reviewed seven of the most recent reports from the huddles. These highlighted incident reporting trends, serious incidents and complaints.

Areas for improvement

We took enforcement action to issue a section 29A Warning Notice because the quality of healthcare required significant improvement. In summary the reasons we issued this notice were:

Urgent and emergency services

MUSTS

- The trust must ensure patients are effectively monitored for deterioration and receive timely support to stay safe. Regulation 12.
- The trust must ensure patients have timely access to urgent and emergency care through improved flow in and out of the department. Regulation 12.
- The trust must ensure risks are adequately assessed and maintain good governance and oversight within the department to ensure patients are protected from potential harm. Regulation 17.
- The trust must ensure detailed and up to date records are kept in relation to provision of care and treatment and it is reflective of each patient's full clinical pathway, and include decisions taken in relation to the care and treatment provided. Regulation 17.
- The department must ensure there are always enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care. Regulation 18.

SHOULDS

- The trust should continue working to improve Covid-19 testing and waiting times for results.
- The trust should review the environment, ensuring there are segregated routes within the department to reduce the risk of cross contamination.
- The trust should work with external mental health providers to improve waiting times for crisis beds and travel arrangements.

Our inspection team

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

This section is primarily information for the provider

Enforcement actions

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	Section 29A HSCA Warning notice: quality of health care