

## CQC ED Must do and Should do Action Plan High Level Plan

Appendix 2 to Agenda Item 6

<b>Completed</b>	8	Action has been completed and there is robust evidence to support that the action has been completed and where relevant embedded in practice
<b>Overdue</b>	0	Action is off track and assessed as unrecoverable within the current timescales and requires urgent action to address.
<b>Off Track with actions to deliver</b>	0	Action is off track and plans are being put in place to mitigate any delay
<b>On Track</b>	0	Action is on track with progress noted and on trajectory
<b>Total Number of actions</b>		8
<b>Percentage of actions completed/on track</b>		100%

No	Recommendations December 2020 Inspection	Self Assessment BRAG Status	Issues Identified by CQC	Core Service Area	Date of completion and closure
EDMD01	The trust must ensure patients are effectively monitored for deterioration and receive timely support to stay safe.	<b>Completed</b>	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.	Acute & Emergency Medicine	<b>16.06.2021 Quality Panel-</b> The evidence received and reviewed included SITREP reports, Governance Board Minutes. It was confirmed to the panel that the action is discussed at daily senior ops meetings and the escalation systems and processes are in place and working robustly. At the time of this panel there had been no cases of patients deteriorating in the back of an ambulance or patients in ambulances waiting significant lengths of time as there had been at the time of the inspection in December 2020. In-depth discussion regarding the evidence seen by the evidence panel. Assurance given by the evidence panel that the evidence is robust, of good quality and over a length of time. The panel were all in agreement and the Chair confirmed the action is closed

## ED Must Do and Should Do Action Plan

**16.09.2021**

<b>EDMD02</b>	The trust must ensure patients have timely access to urgent and emergency care through improved flow in and out of the department	<b>Completed</b>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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. 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.</p> <p>At the time of our inspection the average time between a decision to admit and admission was 8 hours and 45 minutes.</p>	Acute & Emergency Medicine	<p><b>15.06.2021 Quality Panel</b> - Report provided which discussed flow. Monitoring takes place via SITREP, site meetings, governance meetings. Evidence proves there has been improvement since December when the inspection took place. The Quality Panel were all in agreement that the evidence was robust and the Chair confirmed the action is closed.</p>
<b>EDMD03</b>	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.	<b>Completed</b>	<p>The leadership, governance and culture did not always support the delivery of high-quality person-centred care for patients.</p>	Acute & Emergency Medicine	<p><b>15.06.2021 Quality Panel - Departmental</b> Governance meetings are embedded and well attended. There has been improvement in all areas of governance. Closure of Datix's and risks are reviewed weekly. Any divisional risk updates are fed back to the department and discussed within Divisional Governance Board. The panel were all in agreement that the evidence was robust and the Chair confirmed the action is closed.</p>
<b>EDMD04</b>	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.	<b>Completed</b>	<p>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.</p>	Acute & Emergency Medicine	<p><b>15.06.2021 Quality Panel</b> - Audits, spot checks and the ED documentation audits / summary reports have been provided as evidence. Audit results are discussed with the Matron and then discussed staff member. Results also discussed at Care Group Governance Meetings. Latest documentation audit results shared with the panel showing consistency with compliance. The panel were all in agreement and the Chair confirmed the action is closed</p>

## ED Must Do and Should Do Action Plan

**16.09.2021**

EDMD05	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.	Completed	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. 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.	Acute & Emergency Medicine	<b>22.09.2021 Update Quality Panel:</b> - Training data remains compliant at 85.63%. Confirmation that the compliance will be monitored through the Divisional Governance Board and Divisional Management Board meetings through the new reporting process. Based on the discussion undertaken and the fact that the department had met the expected level of compliance, the recommendation would be to close the action. The panel were all in agreement and the Chair confirmed the action is closed
EDSD01	The trust should continue working to improve Covid-19 testing and waiting times for results.	Completed	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.	Acute & Emergency Medicine	<b>15.06.2021 Quality Panel</b> - A report was provided outlining governance process of the Covid testing process. Confirmation of number of SAMBA Machines and tests that can be undertaken and the time it takes for the test result to return. Discussion took place at the panel regarding all evidence supplied. The panel were all in agreement that the evidence was robust and the Chair confirmed the action is closed
EDSD02	The trust should review the environment, ensuring there are segregated routes within the department to reduce the risk of cross contamination	Completed	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.	Acute & Emergency Medicine	<b>15.06.2021 Quality Panel</b> - Once the department can take over the new build a lot of the issues will be addressed. Currently there is only one way in for patients, however a new model has been developed for walk in patients. An environmental assessment has been undertaken by IPC. After in-depth discussion the Quality Panel were all in agreement that sufficient evidence had been presented and the Chair confirmed the action is closed
EDSD03	The trust should work with external mental health providers to improve waiting times for crisis beds and travel arrangements	Completed	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.	Acute & Emergency Medicine	<b>15.06.2021 Quality Panel</b> - There are three times a week system calls in place with the escalation of individual needs of patients. CQC published a report recently identifying a particular problem relating to mental health patients across the whole of Kent. The Department can demonstrate escalation to system partners, and there is evidence that we are working with system providers. Report on Mental Health provided by NHSE (working with the Trust at the time) presented as evidence. The panel were all in agreement that evidence was robust and the Chair confirmed the action is closed