Enter & View Queen's Hospital, Romford: Accident & Emergency Department (including Medical and Elders Receiving Units)

13 June 2016

Healthwatch Havering is the operating name of
Havering Healthwatch Limited
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What is Healthwatch Havering?

Healthwatch Havering is the local consumer champion for both health and social care. Our aim is to give local citizens and communities a stronger voice to influence and challenge how health and social care services are provided for all individuals locally.

We are an independent organisation, established by the Health and Social Care Act 2012, and are able to employ our own staff and involve lay people/volunteers so that we can become the influential and effective voice of the public.

Healthwatch Havering is a Company Limited by Guarantee, managed by three part-time directors, including the Chairman and the Company Secretary, supported by two part-time staff and a number of volunteers, both from professional health and social care backgrounds and people who have an interest in health or social care issues.

Why is this important to you and your family and friends?

Following the public inquiry into the failings at Mid-Staffordshire Hospital, the Francis report reinforced the importance of the voices of patients and their relatives within the health and social care system.

Healthwatch England is the national organisation which enables the collective views of the people who use NHS and social services to influence national policy, advice and guidance.

Healthwatch Havering is your local organisation, enabling you on behalf of yourself, your family and your friends to ensure views and concerns about the local health and social services are understood.

Your contribution is vital in helping to build a picture of where services are doing well and where they need to be improved. This will help and support the Clinical Commissioning Groups and the Local Authority to make sure their services really are designed to meet citizens' needs.

'You make a living by what you get,
but you make a life by what you give.'
Winston Churchill

What is an Enter and View?

Under Section 221 of the Local Government and Public Involvement in Health Act 2007, Healthwatch Havering has statutory powers to carry out Enter and View visits to publicly funded health and social care services in the borough, such as hospitals, GP practices, care homes and dental surgeries, to observe how a service is being run and make any necessary recommendations for improvement.

These visits can be prompted not only by Healthwatch Havering becoming aware of specific issues about the service or after investigation, but also because a service has a good reputation and we would like to know what it is that makes it special.

Enter & View visits are undertaken by representatives of Healthwatch Havering who have been duly authorised by the Board to carry out visits. Prior to authorisation, representatives receive training in Enter and View, Safeguarding Adults, the Mental Capacity Act and Deprivation of Liberties. They also undergo Disclosure Barring Service checks.

Background and purpose of the visit:

Healthwatch Havering is aiming to visit all health and social care facilities in the borough. This is a way of ensuring that all services delivered are acceptable and the safety of the resident is not compromised in any way.

The Accident & Emergency (A&E) Department at Queen's Hospital is one of the busiest in the country, with daily attendances often exceeding 500 patients, with over hundred being brought in by ambulance, mainly by the London Ambulance Service but also many by the East of England Ambulance Service as the catchment area for the hospital extends beyond Greater London, particularly into the Brentwood Borough of Essex. This is a workload some 25% in excess of the designed capacity of the department and contributes to extended waiting times for patients.

In addition, the general difficulty being experienced by all hospital A&E departments is experienced by Queen's, as a consequence of patients being unable to obtain appointments with their GPS in what they regard as an acceptable time; and there remains confusion among the public as to exactly where is the best place to go to receive medical care.

In addition to visiting the main A&E department, the team also visited the Elders Receiving Unit (ERU) and Medical Receiving Unit (MRU), to which patients for treatment or observation that will take up to three days but does not justify full admission.

"Accident and Emergency" or "Emergency Department"?

In passing, it should be recorded that there is a move in hospitals to change the nomenclature of A&E departments. Although "Accident and Emergency" and "A&E" are "brands" that have almost universal recognition among the public, the Royal College of Emergency Medicine and others are pressing for a change to "Emergency Department" and "ED", which they consider to be more accurate and less likely to suggest to patients that the department is the preferable place to go for medical attention to minor ailments. At this stage, however, "Accident and Emergency/A&E" is the term more generally recognised by patients, visitors and other members of the public and, accordingly, this report uses it for consistency.

Description of the premises

This visit was another in a series of visits by Healthwatch members to the facilities at Queen's Hospital. In addition to the several visits by Healthwatch Havering to wards, clinics and common areas by Healthwatch Havering, a visit sponsored by Healthwatch Redbridge had taken place to the A&E department in April 2015 by Healthwatch members who had hearing impairments, in order to assess how well-adapted the department was to meet their specific needs. The team

undertaking the visit now reported had taken the previous reports into consideration before embarking on the visit.

On entering the A&E Foyer, the team noticed that there was a yellow triage point signage.

On entering A&E, just inside on the left was a large sign showing departments and where they are located but it was noted that the sign was out of date because some of the departments were no longer referred to by the names indicated.

There was an electronic board in the reception area giving waiting times in A&E, showing a waiting time of 2hr 30min but this was not accurate as there were patients who had already waited more than 50 minutes and had not even been through the triage process. When the team returned to the reception area after visiting other departments, the sign had been turned off but, when reinstated, it was still showing a 2hr 30min waiting time: but the team noted that patients who had been seen when they first arrived were still waiting to be seen, having only been triaged shortly before the team's return there at the end of the visit, which was well over two hours after their original arrival.

Within A&E, there are 26 beds in the Majors section, 6 beds and 5 chairs in Majors Lite and 8 beds in Resus (Resuscitation).

The team noted that one toilet was out of action on the day of the visit. A hazard sign indicated that there had been a spillage that had not been dealt with; the team asked that it be dealt with promptly. Smells were noticeable in certain areas, although they were not overwhelming. Hearing loops were available in all reception areas.

Despite the recommendations of the team of hearing-impaired Healthwatch colleagues from Redbridge, following a visit in April 2015, there appeared to be no signage suitable for partially sighted or blind patients; it appeared to be assumed that they would be accompanied on arrival by someone who could help them. The reception area for ambulance arrivals appeared to be rather small, with insufficient room for all the staff who were required for handovers.

Baby changing facilities are available in the Paediatric A & E; a seat there appeared to be badly split and holed, and the team suggested that it be removed from the area.

The decor throughout the area was acceptable, a water cooler was visible and two drinks machines were available, although the Costa coffee machine was out of order. The public telephone by the grey rubbish bin was not working.

People waiting for treatment were called by voice – a loud speaker system or other means of notifying people when their "turn" came would be beneficial, particularly as some patients waiting had become impatient and wandered off, and so were not available when called. A TV in the area was in use when we arrived but when speaking to patients at the end of the visit the team was told that, as soon as they had left the area it had been switched off. When the team queried that, it was clear that when switched back on, updates and details etc., were inaccurate and out of date.

There is a red card system for patients who are abusive to staff and a security guard was on duty at the time of the visit, which appears to be a regular occurrence.

Discussion with senior staff

A&E at Queens was designed to handle 300 to 350 patients a day; however, during the winter period September 2015 to April 2016 they saw between 100 -120 patients more than that each day. Indeed, at the time of the visit, they were still seeing around 500 patients a day, and the indications were that this number was unlikely to reduce significantly. There was concern that, if there was no significant reduction in the numbers presenting at A&E, some 20-25% more than the department was designed to receive, then there might be a significant increase in numbers during the coming winter, adding still further to the significant pressures on an already over-extended department.

The numbers seen at A&E seem to be a result of the standard of care given in A&E compared with alternatives: i.e. patients are seen reasonably quickly and blood and other tests are carried out straightaway, whereas other services, such as GPs, did not provide the opportunity to get test results so quickly.

The team was told that A&E staff had held out a one-day event in an attempt to identify and educate people of alternatives to A&E, including providing a leaflet giving details about the GP hub, walk-in centres and GP telephone triage.

Procedures

The team was told that, on arrival, patients who had made their own way to A&E were registered and seen by the triage nurse and then either, if considered low priority, asked to sit in the waiting area until they can be seen or, if considered priority cases, referred through to majors, resuscitation, the HDU or to the children's A&E.

Patients brought in by ambulances are treated in a different stream and enter by a separate entrance. If patients are brought in by an emergency ambulance using "blue lights", staff in A&E will have had conversations with the ambulance crew, enabling them to prepare for patients. The team was not able on this occasion to observe ambulance arrivals and handovers but may do so on a future occasion.

In addition to a trained phlebotomist, all doctors in A&E can carry out phlebotomy and the nurses with red tops also are trained to do so.

Women who are pregnant but not yet registered with Maternity are referred after assessment to the Early Pregnancy Unit or the Maternity Unit.

Patients referred by GPs are triaged in the same way as those who self-present.

Staffing

Currently, there are the largest number of staff in the department: 15 consultants, 12 of whom are permanent and 3 locums (previously there were only six permanent consultants); the full contingency of band 5 nurses (some having recently been recruited from the Philippines and Italy). Staff are trained in sepsis, dementia and learning disability awareness, and safeguarding. Language barriers are overcome, with staff speaking a number of languages.

The team spoke to a doctor who had been in charge of the children's A&E and was now in charge of the whole department. Children's A&E had successfully retained staff by increasing staff training, particularly in governance and safety.

Staff worked a pattern of 12 hour shifts, either 11am to 11pm or 8pm to 8am. Shifts were mapped according to patient numbers, and the number of doctors in particular was mapped to peak times.

They have multiple staff meetings every day. A multi-disciplinary senior clinical team meets each day. They have a meeting in the morning to review incidences. There is also a managers' meeting every week.

Reception staff received induction training and mandatory training including conflict resolution. Bank staff are used who have training in these areas.

Dealing with patients who present with special needs

All staff have received dementia awareness and LD training. There is flagging in the electronic symphony system which is checked when a patient presents showing allergies, aggressive behaviour, mental health, dementia, autism, LD or other special needs. There is a separate team in SRU and MRU who are trained to deal with dementia, autism and like conditions.

There are no observation bays anymore

There is a separate area in the MRU for patients who have psychiatric or psychological needs (including dementia) .

Triage

On arrival, patients' medical needs are assessed through the triage process. A streamer (a GP or senior nurse) sees the patient initially and decides where best they can be treated (including not only A&E itself, but the adjacent Urgent Care Centre or out of hours GP service which, though located in the hospital, are separate, GP-based services); a consultant is available who can stream more complex cases if needed. Few patients were tuned away, although some would have an inevitably lengthy wait before they could be seen.

At the time of the visit, there was a long waiting time for triage in order to clear and improve the flow of ambulances.

Questions to patients waiting in A&E

Patients waiting A&E were asked whether they were happy with the information provided about waiting times at various stages. Concern was expressed that the waiting times displayed on the screens were not accurate and that there was no real time information; patients did not know why they had to wait for so long.

Overall, the impression of patients was that A&E was clean and tidy but there was lack of information. Patients did say that they felt that they had been treated with dignity and respect and that the staff were very good.

Elders Referral Unit

The Unit appeared clean and tidy.

The team was told that, during admission, patients were assessed for special dietary requirements, and the kitchens were informed about them. The red tray system (to identify patients who require assistance with feeding) was still in operation. Mealtimes are protected. Many of the patients in ERU were unable to feed themselves or indicate that they were hungry so the staff would ensure that patients are fed on the Unit and are not moved at mealtimes.

The butterfly and sticker systems were in use. However, the team was told that relatives had to be spoken to about the use of flags.

Two pharmacists were based on the ward every day. Every medicine need was recorded and the pharmacist also checked stock held on the ward daily. The team saw the pharmacy store, which was very secure with locks on doors and medicines were locked away within the store.

Ward rounds were carried out at about 9-9:15am with consultant, physiotherapist, pharmacist, OT and social workers. Patients who were considered to be ready for discharge would be identified. The nurse practitioner was able to fill prescriptions for patients who required antibiotics, steroids etc. on discharge. Patients requiring these medications were discharged from the Unit without having to go to the Discharge Unit (visited by Healthwatch in October 2015 – see separate report).

A dementia nurse was available if needed, as were two social workers.

Care plans would be discussed with family members. Patients nearing death wishing to go home would be cared for by Macmillan nurses.

The staffing ratio was 5:1, with 6 (2 band 6) nurses on duty for the morning shift and 6 (3 band 6) nurses for the afternoon shift. In addition, there were 4 Health Care Assistants (HCAs) on duty in the morning and 3 or 2 HCAs in the afternoon.

The staff spoken to commented that the shift patterns were working well and the patients seemed happy.

Reaction to fire alarm

While the team was in the ERU, the fire alarm sounded a continuous tone, which indicated that there was a fire is in the Unit – it was not a fire drill. Several members of staff spent several minutes trying to locate the source of this fire. They followed the procedure laid down to identify the location number which was highlighted but there appeared to be confusion as to which room was the location of the fire. From the team's observation of the incident, there did not appear to be a clear idea of the room location (no master plan to pinpoint the room quickly) and had there actually been a fire it would have taken many valuable minutes to finally locate the source.

Staff on the Unit were aware that no one should enter or leave the Unit when trying to locate the source of the fire and individual doors were closed; however, a visitor was able to come into the Unit during this time.

The explanation for fire alarm being triggered was that a patient used an aerosol spray in the room identified as the source of the fire, and the delay in locating the "fire" was that nothing appeared amiss in that room when staff first visited it, leading them to look elsewhere for the cause of the "fire". The matron made sure that, after the "fire" was located, she went round to each ward and reassured patients, visitors and staff that all was well and explained the cause of the fire alarm.

The team considered that, although the matron handled the aftermath well, it took an inordinate length of time to locate the "fire" and the explanation for it, that there appeared to be no definitive plan to refer to, that staff wasted time milling around, looking for the source of the "fire" that it was inappropriate for a visitor to be able to enter the ward while the alarm was sounding. There was clearly a need for more and better fire drill training for the staff.

Questions to patients

The team spoke to a patient who said they had been in the Unit six days, although the team had been told that patients stayed no more than three days. The team spoke to the matron about this. The patient was happy with the service they had received and the treatment that was proposed.

Medical Receiving Unit

The Unit was clean and tidy. The team noted that a red tray system was in operation, and that flowers were used to indicate patients with special needs.

Visitors were welcomed at mealtimes as that gave opportunity for **information to be obtained** about the patients.

Two pharmacists were available to join rounds or attend on their own in order to ensure that medication packs would be available in a timely manner for patients when patients were discharged. There were three rounds a day between 8.45am and 4pm. About 40% of patients were discharged each day.

There were two link nurses and an HCA to deal with patients who were diagnosed with dementia, and two social workers, of whom one was on duty at a time. There is access to a social worker at weekends.

There is no procedure for Care Plans or Pathways as patients in MRU are actively receiving treatment.

There are 7 nurses and 3 HCAs are on duty during the day and 7 nurses and two HCAs during the night.

Recommendations

1. More real time information, showing patients where they are in the system and accurate information on waiting times, is urgently required.
2. Although the waiting time at the time the team carried out this visit was shown as 2.5 hours, a number of patients had already been waiting to be triaged for several hours; as the official waiting time for treatment only starts once triage is completed, patients are often left for hours wondering what would be the next step for them. This lack of clear information can only be to the patients' detriment and clearer communication throughout the waiting period is vital. It is recommended that the waiting arrangements be thoroughly reviewed in order to make the (inevitable) waiting period less stressful for patients and, in particular, that better arrangements are made for letting patients know when it is their turn for treatment (such as a paging system, that would enable those who are able to, and wish to, for example to visit the main hospital reception area to buy refreshments, books or magazines without the fear or risk of losing their place in the queue)
3. Some of the information on the notice board in A&E, showing where the various departments are, is out of date: this is confusing for patients and needs to be updated.
4. On the basis of what was observed during the fire alarm sounding while the visit was taking place, staff lack awareness of basic fire procedures. Procedures need tightening so that the seat of a fire can be located quickly and dealt with, and visitors are not allowed to enter the ward when the ward should be on lock down following the fire alarm sounding.

5. **Staff should be trained regularly in fire procedures and be familiar with the location of each room, and their numbers. A room layout diagram alongside the fire panel would be helpful.**
6. **The number of patients attending A&E is currently running at some 20-25% higher than the department was designed to take. Given the inevitable concern about the possibility of even higher numbers presenting in the coming winter months, BHRUT should publish its plans for dealing with any additional workload in a timely manner.**
7. **Healthwatch Havering is fully cognisant of the difficulties faced by BHRUT in recruiting staff – at all levels – in order to ensure that the full staff complement is available at all times. However, it does seem from the evidence of this visit, and other comments made by patients to Healthwatch, that an improvement in triage arrangements would lead to better outcomes, including the direction of some patients to more appropriate sources of treatment, such as GPs or walk-in centres. Healthwatch therefore welcomes the experimental triage arrangement announced subsequently to the visit now reported on and hopes that it – or something similar – will become a permanent feature of the A&E service.**

The team would like to thank all staff and patients who were seen during the visit for their help and co-operation, which is much appreciated.

Disclaimer

This report relates to the visit on 13 June 2016 and is representative only of those residents, carers and staff who participated. It does not seek to be representative of all service users and/or staff.

Participation in Healthwatch Havering

Local people who have time to spare are welcome to join us as volunteers. We need both people who work in health or social care services, and those who are simply interested in getting the best possible health and social care services for the people of Havering.

Our aim is to develop wide, comprehensive and inclusive involvement in Healthwatch Havering, to allow every individual and organisation of the Havering Community to have a role and a voice at a level they feel appropriate to their personal circumstances.

We are looking for:

Members

This is the key working role. For some, this role will provide an opportunity to help improve an area of health and social care where they, their families or friends have experienced problems or difficulties. Very often a life experience has encouraged people to think about giving something back to the local community or simply personal circumstances now allow individuals to have time to develop themselves. This role will enable people to extend their networks, and can help prepare for college, university or a change in the working life. There is no need for any prior experience in health or social care for this role.

The role provides the face to face contact with the community, listening, helping, signposting, providing advice. It also is part of ensuring the most isolated people within our community have a voice.

Some Members may wish to become **Specialists**, developing and using expertise in a particular area of social care or health services.

Supporters

Participation as a Supporter is open to every citizen and organisation that lives or operates within the London Borough of Havering. Supporters ensure that Healthwatch is rooted in the community and acts with a view to ensure that Healthwatch Havering represents and promotes community involvement in the commissioning, provision and scrutiny of health and social services.

Interested? Want to know more?

Call us on **01708 303 300**; or email **enquiries@healthwatchhavering.co.uk**

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