East Kent Hospital Trust

Research Report on the Accident and Emergency Departments of

Kent and Canterbury Hospital

• • • •

Queen Elizabeth the Queen Mother Hospital

• • • •

William Harvey Hospital

David Cooper
October 2001 to November 2002

KENT AND CANTERBURY HOSPITAL 3
Bed Blocking 4
Triage / Reception 6
Streaming major / minor injuries 7
Staff Morale 8
Blood test / X-Rays 9
Information Technology 10
Conclusion 10
QUEEN ELIZABETH QUEEN MOTHER HOSPITAL 11
Mission: 11
Current position: 11
Proposed changes: 11
Waiting Area Registration: 11
Patient Information: 13
PA system – calling patients: 13
Security: 14
Children's play area: 14
Reception area improvement: 14
Other matters: 15
Bed Discharge: 15
Patients: 16
Good news: 16
WILLIAM HARVEY HOSPITAL 17
Mission: 17
Staff: - Doctors 17
Staff: - Nurses 17
Procedure Room: 18
Tests: 18
Waiting Room: 18
Food and Drink Machines: 19
Telephones and Television: 19
Reception: 20
Triage: 20
Flowers, Pictures, Magazines: 20
Majors: 20

KENT AND CANTERBURY HOSPITAL

ACCIDENT AND EMERGENCY DEPARTMENT

FINAL REPORT

Following my Interim Report dated 28th October 2001, see Appendix A, I have had the opportunity to speak to a number of management and staff. I have visited four other local Hospitals and have had further discussions with North Tyneside General Hospital.

At this point I would like to thank you very much for allowing me access to management, staff and patients to permit me to compile this Report.

During the whole process I have tried hard to be totally objective and fair and to produce a balanced Report. I, as you know, have no 'axe to grind', all I have tried to do is to seek the truth from everybody I have spoken to and, if possible, bring forward ideas to improve the KCH A&E Department.

Unfortunately, it will not come as a surprise to you for me to report that the A&E Department at KCH is in almost continual crisis and cannot proceed in the same fashion for much longer before it collapses. Staff morale is extremely low, see Appendix B, the resignation rate is very high; four nurses resigned in one day, 27th October.

Unless changes, highlighted below, are made very quickly the Department will find it very hard to continue to the time when the PFI Initiative comes in, whenever that might be. Some of the Management I spoke to confirmed my view.

To turn the unacceptable position around so far as KCH A&E is concerned I believe that there are SIX areas that need immediate attention. They are:-

1. Bed Blocking
2. Triage/Reception
3. Streaming Major/Minor injuries
4. Staff morale
5. Blood tests/ X- rays
6. Information Technology.

Bed Blocking

Over the last year, I am told by a number of A&E staff, Bed Blocking has become a huge problem. Prior to 2001 the problem was nowhere near so bad. On two separate visits to the Bed Bureau at WHH during the week beginning 5th November there were 34 and 36 patients waiting on trolleys throughout the Trust. On 12th November on a further visit to the Bed Bureau, there were 45 patients on trolleys across the Trust.

Doctor Beckett and staff nurse Anne suggested to me that 30 extra beds are needed in each Hospital to relieve the problem. Hopefully when other measures, described below, are put into place that number will reduce to perhaps half or less.

I am indeed hoping that the figure of 90 is a little overstated because without more statistical information, not available at present, proper balanced decisions cannot be made.

In my quest to find solutions to the Bed Blocking problem I visited three local Hospitals and spoke to North Tyneside General Hospital. The results were as follows:-

- **Darenth Valley** - Bed Blocking is acute. Mr. John Thurston, A&E Consultant, told me that the Hospital has 400 beds, it should have 560. At the time of my visit Friday 9.15am. there were 14 patients on trolleys.

- **Kent and Sussex, Tunbridge Wells** - Acute bed blocking problem.

- **Medway** - NO BED BLOCKING PROBLEM. - See Appendix C for more details.

- **North Tyneside** - NO BED BLOCKING PROBLEM - Could not explain over the telephone why that was. Needs a visit and investigation I believe.

After considering the above evidence I have concluded that to rid the Trust of this huge problem the following needs to happen.

1. Sue Travis, with a discharge co-ordinator and a representative from Social Services, should spend half a day at Medway Hospital to observe the Meeting which takes place there on a Monday morning and which is referred to in Appendix C at paragraph 4. I have spoken to both Pauline Denine at Medway, telephone 01634.830000 x 3969 and to Sue Travis and they are both keen for this to happen.

2. The practice of 'off legs' practiced by GP's should be investigated because I understand that currently GP's can refer patients to Hospital to 'get them off their back', especially on a Friday afternoon. No record is kept apparently of who the GP's are, why they are sending patients or if the patients should be referred in the first place. I gather some GP's abuse the system for political or other reasons. They need to be 'brought to book', if that is happening, because that alone makes the bed blocking worse.

3. Information Technology needs to be brought to the fore very quickly. As you know the Bed Bureau operates through the telephone system with manual wall boards at a cost of around £200K per year.
   I had a meeting with David Overden and Mario Guarino and it appears that the IT department is working away at various software solutions and has hardware available but not too many Managers know about it. There are apparently 200 PC's available to be distributed to A&E, Wards and other areas but they are currently in store.
   I enclose a copy of an e-mail received from Mario Guarino, see Appendix D, which states part of the current position and which I hope you will agree needs some urgency behind it. I did ask the Question ' Does David Astley know about all this? I was told, 'Probably not.'

4. I would like to see the Bed Bureau totally computerised as soon as possible, Paul Brown agrees. Each Ward and A&E needs a computer terminal linked to the Bed Bureau. David Overden presumably has the cost of achieving this, some of which has already been allocated and spent on the 200 PC's and software referred to above.

5. Once the terminals are in place it should become the responsibility of the Site co-ordinators, not the Ward staff, to operate the bed information system 24 hours per day, and seven days a week and not five. I understand that currently the last information passed from wards to the Bed Bureau is late afternoon on a Friday and the next is Monday morning. That should not be so should it?
   Having a number of different people responsible for keeping the Bed

Bureau up to date is probably not a good idea. The sole responsibility should be with one person so that the point Mario makes in his first paragraph does not happen. The whole operation should become more streamlined and efficient to reduce the number of extra beds required.

6. After all the above measures have taken place there should be enough evidence available to determine how many extra beds are required to stop 'trolley waits' above the new target of four hours.
   It is quite possible that very few extra beds will be needed if everything is sharpened up and a 'mind-set' develops as at Medway. If however extra beds are still needed another practice that apparently takes place, and causes certain staff to be unhappy, is the transferring of some patients from one Trust Hospital to another by Ambulance. According to Sue Travis it is a daily occurrence; Paul Brown thought that up to 10 patients a day were affected. No actual figures appear to be available and nor does the exact cost to the Trust of the transportation. Whatever the cost to the Trust it would make more sense to spend that money on extra beds rather than with the Kent Ambulance Trust.

7. Finally, it would probably be a good idea, as Medway have done, to send a relevant team to North Tyneside to study how they have changed their A&E operation and achieved a no Bed Blocking situation. The lead Nurse there is Mr. David MacPhee, see Appendix E.

Triage / Reception

Currently, as you know, the above two functions are separate. The incoming patient registers first with A&E Reception and is then called by the Triage Nurse, sometimes over two hours later. Mrs. Moorcroft, an A&E Receptionist for 10 years, tells me that 30% of people attending A&E should not be there because their injuries do not justify the considerable services of A&E. At Darenth Hospital the figure is as high as 50%.

Whilst I appreciate that people pay their taxes, suffer from poor GP service, they, in my view, should not 'clog-up' the A&E system.

In the future I would like to see Reception and Triage working from the same desk and not two separate desks. I have found that since I came to this conclusion that that is the way it works at North Tyneside.

I believe that the intending patient, when entering A&E, should firstly be assessed by the Triage Nurse, immediately given advice (via a NHS Direct computer link if necessary, as at North Tyneside) and if their injury can be dealt with elsewhere i.e. a Pharmacy, GP, minor injuries unit they should be referred there.

Only if their injury does require treatment in A&E should the receptionist admit them via computer. All intending patients should be handed a personalised leaflet, see Appendix F, to acquaint them with the workings of A&E. This leaflet or similar should be sent to all schools, libraries, Kent University and published in local newspapers. I am told people do need educating about A&E services so that the pressure is taken off the department, making the life of the staff there more bearable and perhaps enjoyable. One staff nurse told me that if the waiting room is full she informs the patients that there is a 4/5 hour wait for minor injuries. Within ten minutes the waiting room is almost empty.

I appreciate that this area is sensitive and needs close supervision but it should be possible to achieve if staff are properly briefed and have sufficient experience. There were 11,426 people registered in A&E between 1st July and 30th September and there were 28 complaints in the same period. (0.24%). This information appears to confirm my patient research.

Streaming major / minor injuries

This arrangement works very successfully apparently at North Tyneside and has had a dramatic effect for the better when introduced. Medway and Tunbridge Wells are also very pleased with their streaming, which relieves the pressure on the Majors.

I have visited Buckland Hospital Minor Injuries Unit and spent 20 minutes talking to a Sister who told me that the Unit works very well and has done for six years. They receive between 19 and 20 thousand patients a year with 10 staff covering 7 days. There appeared to be no pressure and the staff were not unhappy. Could not the arrangement there be started at Faversham and Herne Bay again to relieve the pressure at KCH?

I have been told by a staff nurse, after a nurse group meeting with Liz Hewitt, that streaming is going to start during the Winter, with cubicles 5,6 and 7 being used and staffed by new nurses, not existing nurses. Howard Jones confirmed

that no real structural alterations need be made to open a Minor Injuries Unit. Paul Brown however tells me that the idea has been put on hold.

As you will see from Ramzi Freij's comments 'front loading' is the answer to a lot of A&E problems. Purely from a logical point of view it does make a lot of sense.

If there is no appreciable money available at present to recruit additional nurses could not, with the help of Christine Sidwell, one or two of the existing nurses on each shift, who I believe are called 'minors nurses', actually work in cubicles 5, 6 and 7 between the hours of 0800 and 2000? According to one Schedule dated 11th October 2001 in Appendix G, that would still leave five nurses for Triage and majors.

It may be just a logistic problem or even a 'mind-set' again, but whatever it is a little flexibility would be very helpful and constructive.

Staff Morale

As previously reported this is very low, not of course helped by the knowledge that sometime in the future the department may well end up as an MIU, which is not what most nurses joined A&E for. As Christine Sidwell explained to me, majors may be gruesome but that is why nurses do that job because they can give maximum benefit to patients.

There is already a feeling apparently amongst the staff that Management are winding down the department. They are not sure which 'side' Management is on. Management is not visible enough in the department. (As an aside, how often do members of the EKHA visit A&E to see the conditions for themselves?).

I have actually been asked by one of the A&E Consultants to interview nurses at WHH and QEQM to see if their morale is as low as KCH, but I replied that at the moment at least, it was KCH which was the subject of my research.

This is, of course, a difficult subject but it does need to be tackled, I think the only way is to make the staff feel more inclusive and to endeavour to bring about the changes referred to in this Report. The staff need to be able to see and understand that something is being done to try and improve their lot.

I have had many staff members asking to see a copy of my Report because they are very interested to see things improve, both for themselves and the department

in particular. They have been told that for the moment at least the Report is for you only.

There are two matters which I would like to bring to your attention.
The first one is something that Christine Sidwell wished to be in my Report and that is Nurses clothing. Currently most nurses I saw in A&E are dressed unlike most people's perception of nurses, with a tunic that could be the tunic of a domestic or porter or anybody. In some of the three Hospitals I visited I did see nurses that I would call 'properly dressed' with a blouse or shirt in a colour depicting whether they were a staff nurse or sister. A lot of patients in A&E are of course elderly and confused and sometimes A&E is so busy that it must be very difficult for them to distinguish one person from another. I believe that it would give the nurses more creditability and respect if they were 'properly dressed' in different colours with their 'rank' conspicuously shown.

The second is lack of training to perform as a shift co-ordinator. Apparently no special training is given, which it probably should be, because an A&E department, like any other department in life, if not properly managed will not function to its full potential.

Blood test / X-Rays

According to one Junior Doctor the current practice of obtaining both blood test results and X-Ray results needs changing , for two reasons.

1. The Junior Doctors have to waste their valuable time telephoning the Path. Lab. to inform them that there is a sample for testing, then telephone the porters to ask them to deliver the sample. The collection procedure is almost as time consuming.

2. It apparently depends who is working in the Path. Lab. as to how long it takes for the tests to come back, which sometimes is many hours. In the meantime patients are on trolleys and, if the results are negative, often they could have gone home earlier. This area needs tightening up.

At Darenth Hospital they have a Shute and the results appear on the computer screen within 30 to 120 minutes depending on time of day.

At Kent & Sussex Hospital blood tests take up to two hours. X-Ray results are apparently instant.

At North Tyneside blood tests take up to two hours.

While it may not be feasible to install a Shute at KCH could not the porters be organised to carry out a regular call on A&E to take samples etc. The Junior Doctors can no doubt suggest a time schedule.

Information Technology

I have previously mentioned I.T. and how I believe that it should become more urgent in its promotion of I.T. within the Trust, at least for KCH A&E and the Bed Bureau.

Before my research started I drafted a document, see Appendix H. This document was intended to give Management more information because I believed that that information was not being collated. I was apparently right. The right hand column detail is known but not the rest.

On 11th October Dr. Beckett complied the figures in document 2 in that Appendix, which as you will see provides very interesting reading. Ten medical staff were on duty over a 13 hour period and over a similar period there were 10 major and 20 minor injuries.

I believe that the I.T. Department could be very helpful and have software written for this Matrix so that Management can have, on a daily basis, the information set out, which will not only be useful to them as a 'management tool' but to the powers that determine budgets.

Conclusion

I do hope that this Report is of use to you and your colleagues. Fortunately I am still able to devote the same amount of time to any further work you might wish me to undertake.

David Cooper
14th. November 2001.

QUEEN ELIZABETH QUEEN MOTHER HOSPITAL ACCIDENT AND EMERGENCY DEPARTMENT

Mission:

To suggest proposals to develop, with the help of the Management and staff, the QEQM A&E Department into an example of the best practice within A&E Departments in the NHS.

Current position:

In July 2002 the above department is very modern with a good spread of IT equipment to help the organisation run smoothly. The staff appear to be very happy and motivated. Matron informed me that there are no Nursing vacancies and there are other Nurses now applying to join the department.

The patients first impression when attending A&E is the reception area. At QEQM the reception is modern, large with lots of light and in the recent heat, cool. It is well decorated, clean and the seating etc in good order. Even so I believe with a number of changes the reception area can be even better, both for patients and staff.

Proposed changes:

These proposals have been discussed with Liz Hewett, Matron, one Triage Nurse, three receptionists and Philip Blanch, the project co-ordinator, all of whom expressed their agreement and who added their own views , which I have incorporated into this Report.

Waiting Area Registration:

QEQM receives in A&E on average 140 people each day and in the busy periods, which I am told can be at any time, there are people queuing at reception in a line out towards the entrance door, sometimes up to eight people deep. I did see for myself, on two occasions, some six to eight people queuing in this way. These people are not under any sort of control and the sub-waiting area, shown marked A on the attached plan, can get very untidy with people all over the place. The walkway between the Waiting Area to triage and the treatment area gets blocked and is very unsatisfactory for patients trying to get from the waiting area to triage and/or treatment.

There is a further problem with the current registering arrangement, which allows people not yet registered at reception to listen to the private details of those registering. I am told by reception that this situation causes concern for some patients because what should be a private conversation is being overheard by others in the queue.

My first proposal to overcome these two main problems is to install a Banking Hall type semi flexible barrier. It must have some inflexibility and flexibility according to Matron, to deal with firstly the problem of drunks etc., who might use it as a weapon, and secondly to be able to be moved so that if a trolley needs to cross the sub-waiting area it can do so unhindered. The barrier would be sited say on the dotted line indicated on the plan and marked B. Having the barrier would then allow only one or two people at a time to register, keeping the third, fourth and so on behind that barrier. Some privacy and control would then be achieved for the benefit of both patients and reception staff.

People standing in a queue, whether behind a barrier or not, still create an obstruction, so I propose that they should be directed by appropriate signage to sit in turn, waiting to register on the current seating installed, shown on the plan marked C. There are in fact four seats and not two as shown on the said plan. Those seats will not be sufficient to accommodate everybody, so I suggest that the seats marked D on the plan are rearranged. If this is done, another cause of embarrassment could be alleviated, as the first row of those seats is very close to the glass partition of the reception, much closer than the plan shows. While I was behind the glass I found four 'hard' looking men sitting on those seats and staring into the reception area, potentially intimidating for the receptionists. They were also well within earshot of people registering.

I have considered these matters at length and have discussed with Matron and Philip Blanch the possibility of moving the inner main doors marked E on the plan forward towards the main entrance door. This will give more room for seating to be installed at C but while the theory is good the practice may not be. I would however like to meet the relevant person on site to discuss this proposal, before any changes are made, because it is crucial to the changes I am suggesting.

Patient Information:

Moving on, I understand from the receptionists that they are not permitted, at present, to inform registering patients the expected time they will need to wait to see a Doctor or Nurse. This situation seems totally illogical, both to me and Dr. Marie Beckett, because both at KCH and WHH the patients are given this information, either orally or by signage.

This apparent lack of information at QEQM also causes concern for patients. I do understand however from Liz Hewett, that an LED sign is to be installed in reception, to provide information on waiting times for QEQM and the nearest MIU's, which will then overcome the lack of waiting time information.

I would like to think that this proposed sign will be installed as soon as possible because it will 'kill many birds with one stone'. It will make the waiting patients happier because it will give them some certainty. It should reduce the numbers registering at QEQM by probably up to 25% or 35 people per day and even-up the distribution between QEQM and the closest MIU's. The MIU's can then be used more effectively. I am not aware of the cost of the LED sign but whatever it is, it is so valuable for the good organisation of the department. It should be installed and the cost hopefully deferred to the supplier, for a short time, until there is a budget for it.

PA system – calling patients:

My next proposal is to make the calling to the waiting area by the Triage nurse a little more 'professional'. At present both Triage nurse and Doctors have to shout across the sub-waiting area to the waiting area. On occasions the call is not clear enough, so that patients do not hear their names called. I would suggest a PA System be installed between the Triage room and the waiting area, in fact I understand funds are being raised to cover this. The Triage Nurse would not then have to waste time leaving her room, and hopefully the patients might hear their names better.

The Doctors also are having to walk from the treatment area to the waiting area to shout out the name of the next patient. May I suggest that in future the Triage nurse, after she has seen the patient, should direct the patient to the row of six seats at the entrance to the minor treatment area, shown marked F on the plan, until they are full. The Doctors will then have a shorter walk and it again becomes more professional. Dr. Beckett likes this idea a lot.

If a PA system is installed for the triage Nurse, she should have a CCTV monitor in her room so that she can see both the waiting area and the area referred to above marked F. She will then know the position at anytime of the volume of patients in both areas. A camera will have to be installed so that the six seats can be viewed.

Security:

I have been asked by the reception office manager to have the door between the reception and the minor treatment area, shown marked G on the plan, to be made more secure if possible. This is because people who have not yet been called are just wandering through into the treatment area unsupervised. The receptionists drew this to my attention and I did see the problem myself.

At present there is only one button to release that door, which is in the wrong position; there should be a button at the desk of each receptionist so that they can have control without leaving their seat.

Apparently there is some violence towards receptionists from time to time and there is now a panic button connected directly to the Police. I was asked by the receptionists, however, to have the door between them and the minor treatment area to be kept locked with a glass 'porthole' installed so that they can see if a member of staff wishes to enter.

Children's play area:

There is a very good children's play area but it does not seem to be well signposted. Would it be possible to arrange for better signage so that children who are not patients can go there to play as soon as possible, to have them away from the waiting area.

Reception area improvement:

The whole reception area is now more like that of a private Hospital, and why not! I believe that with a few small additions it could make it even nicer, and probably more patient and staff friendly. It might even reduce aggression as people generally behave better in better surroundings.

I would like to propose the following additions:

1. Welcoming signs –‘ Welcome to QEQM – We are here to help’ (example)
2. Slightly more customer friendly receptionists (I understand from Lesley White that a course is being prepared for training)
3. Some live flowers behind the glass, changed weekly at a cost of around £10.- per week
4. Some magazines supplied by a local newsagent, who could sponsor their supply
5. Hang a couple of nice prints on two very bare walls (I know an artist in Molash who paints Kent scenes and who would probably loan two prints from time to time. I could probably arrange this!)

I believe that with the above additions the whole reception ‘experience’ can be improved to almost perfection. Which would be good.!

Other matters:

Turning to matters other than the reception area I have spoken at length to Matron, Dr. Beckett, Dr. Ruth Bowen, Staff Nurse Denise, Avril McConichie, Mandy, a discharge co-ordinator, and to two ward clerks.

The overall impression I have got from my three separate visits to QEQM A&E department is that it is now a great place to work. One Nurse told me that three months ago there was nearly a mass walk out of Nurses because of then situation. Things were so bad that she did not want to come to work, now everything is different. The pressure has been taken off. The ward clerks have helped considerably, the bed discharges are now working properly and the whole atmosphere has changed.

I would say that it is so different from the situation I found at KCH from last October through to May this year. I cannot really believe the difference and the advances that have been made. I am sure that CHI will see a huge difference from last February to this coming September, if it keeps going as it is.

Bed Discharge:

I have mentioned already the improvement in Bed discharges, and Avril and Mandy confirmed that there are now meetings every day, sometimes two or three a day, to plan and effect satisfactory bed discharges. All 16 wards are visited around the clock to keep the situation up to date. The discharge position is

logged on schedules, shown to me, so that each discharge nurse knows at any time the discharge or otherwise position of each ward.

I was told that the social service people are now 'on board' where they were not before, and they are working together with the nurses and not so much in isolation as before. Meetings with social services happen each week now and to some extent, I am told, their 'power' has been taken away. I was also told that the Bed Bureau at WHH features a little less than before because QEQM has become slightly more autonomous.

The current situation regarding bed discharges is a far cry from the situation only some two months ago.

Patients:

On my three separate visits to QEQM I did not speak to patients, I purely observed their demeanour and the calm that prevailed. I felt that it was unnecessary to talk to them for those reasons, and also I had in mind the 98% approval rating I received at KCH in October 2001, where the conditions were totally reversed. At no time did I see anything but apparent satisfaction from patients in the waiting area and the treatment area.

Good news:

I am not aware of the Press coverage of the A&E department but I would like to suggest that when hopefully all or most of my proposals are put in place, if agreed, the Press are invited in to be shown the now high standard of QEQM A&E department. It would be good for everybody in East Kent to be aware of the standard that now exits in August 2002, particularly after all the adverse publicity in general over the past years.

I would like to thank you for the opportunity to carry out this research. I have found it very rewarding and I do hope that I have been of help to you.

QEQM A&E department is a department that I believe the EKHT can be proud of, thanks to good sense, action and a happy atmosphere.

David Cooper
2nd. August 2002

WILLIAM HARVEY HOSPITAL
ACCIDENT AND EMERGENCY DEPARTMENT

Mission:

To suggest proposals to improve the working conditions of staff and to improve the facilities for patients.

Staff: - Doctors

There are apparently too few Doctors, during the night period there are sometimes only two Doctors to cover both Majors and Minors. Doctor Bruce Jenkins, a locum, and Doctor Loukas are both concerned about this situation because on occasions the 'Minors' Doctor gets called to work in Majors, and leaves Minors with no Doctor on duty.

Staff: - Nurses

I have spent some time talking with Matron, Paul McGahan, Sister Jackie and Sister Phillipa. I was told that there is a 70% to 80% dependency on Agency Nurses. This is a most unfortunate position for a number of reasons: 1. There is an apparent lack of commitment on the part of those agency Nurses because they do not 'belong'. 2. Sometimes they are not even A&E Nurses and they do not know how a specialist department like A&E works, and the Shift Controllers have to waste time instructing them. 3. Cost: that must be prohibitive; apparently some Agency Nurses are paid £50 per hour. Has any analysis been done on the cost because surely that money could be spent on more relevant needs?

Matron informed me that Nurse retention is now good but at any one time he is 10% short of establishment and he is not sure that the establishment figure is high enough anyway.

Apparently WHH retains some 39% of admissions into A&E, some 20% above the National average, mainly because it has a catchment area of around 307,000 people and for some reason receives more Majors than either KCH or QEQM.

At QEQM, as you know, only around 30% of Nurses are Agency. Margate and Ashford are totally different places in many ways but could a solution to the huge disparity between agency Nurses at the two sites be overcome with some imaginative thought and action?

In my recent QEQM Report I referred to a full complement of Nurses in A&E with Nurses wishing to join. I do appreciate that Ashford is 35 miles from Thanet but now that WHH is improving, a description given me by everybody I spoke to, could not Nurses within the EKHT be encouraged to go and work at WHH A&E department?

There appears to be a lack of Nurse Practitioners at WHH. Is there a recruitment programme because in other Hospitals within the Trust, Nurse Practitioners are a very valuable asset.

I was told, and did see in the MIU for a period of two hours between 11am and 1pm, that only one locum doctor and a trainee care assistant were there to treat about 20 patients in the Waiting Room. Waiting times, I was informed by the receptionists, can vary between 1 hour and 5 hours depending on staff levels and patient numbers.

I was asked by Liz Hewett back in July to draft a Leaflet, which I did, to advise people to use other MIU's and to consult their GP or Pharmacist, and not wait for treatment at an A&E department if it was not appropriate. I do believe once that Leaflet appears and is given to each person registering, before they register, that that one thing alone will reduce pressure on the system and make the need for more Doctors, Nurses and seating less urgent.

Procedure Room:

I was asked by two Doctors for a Procedure Room, similar to the one at QEQM, because apparently there are no proper facilities in the MIU for stitching patient's wounds. Also the lighting in that Unit is not good enough.

Tests:

Blood tests results are taking too long to come back, usually 3 to 4 hours. I was shown by Sister Phillipa the 'admissions board' in Majors, which was full of people's names only awaiting a blood test result. Could something be done to speed up the results because patients are being detained unnecessarily at times.

X-ray results do come back in good time.

Waiting Room:

Considerable improvement could be made to this Room.

I have had discussions with Matron, Ann Blair and the receptionists and they agree with the following suggestions for improvement.

Seating:

Currently there are **27** chairs in the Waiting Room, at QEQM there are 60 seats. I was told that it is quite common for people to have to stand in the Waiting Room because of lack of seats. This is not good!

I would like to re-arrange the seating to increase the number to **45** seats, a 66% increase. Please see the plan attached to this Report. The seating would be the same type as installed at QEQM, which is modern and more appropriate to the refurbished department. I have of course taken measurements of the seating and the space between the rows of seating at QEQM, and have drawn it on the plan, having measured the area at WHH in the waiting Room which is available for seating.

Food and Drink Machines:

It is probably not an overstatement to say that these machines are an 'eye sore' in the Waiting Room. Matron wishes at least four machines to be banished, including the gaming machine, which is not used, and I agree.

There should by common consent be just two machines, one for drinks and the other for food. They can be sited as shown on the plan marked F and D.

Having taken all of the machines from the 'east wall' that frees up the whole wall, some 24 feet, from the door of Majors to the beginning of the corridor through to the main Hospital where 12 seats can be sited.

Telephones and Television:

I understand from Matron that the two wall mounted telephones on the 'west wall' are being removed to the lobby entrance. This is a great idea because it will remove the 'aural nuisance' out of the Waiting Room and free up the whole of that wall, some 18 feet, from the MIU entrance to the Children's Play area door for a further 10 seats to be sited there.

The Television set is currently on an irrelevant stand on the 'south wall' which Matron agrees should be moved to the 'east wall' and put on a wall bracket. The brackets cost £14.99 from B&Q and I will donate one because I use them for my CCTV installations. With the TV on that wall it will mean that patients not wanting to watch TV will not have to, because they can sit with their backs to it.

Reception:

I cannot make any recommendations to improve Reception because there is not sufficient space to do what has been recommended for QEQM. Unfortunately I do not see any answer to the problem of a lack of privacy and queuing at Reception.

Triage:

I have spoken to two Triage Nurses and they have no suggestions for any improvements except they felt that better signage was required. At present the Triage sign is on the sliding door and when that door is open the sign is not visible. There should be a large Triage sign on the wall by the door of Triage.

There is a sign asking patients not to drink or eat before being seen and it is felt that that this sign is too small and should be enlarged, because patients are still consuming food and/or liquid, which hinders treatment sometimes. Is it possible to include this advice in the new leaflet as well, if it is not already included?

Flowers, Pictures, Magazines:

Again, as with QEQM, can some live flowers be placed in Reception, some pictures on the walls and some magazines be placed in the Waiting Room, to give the place a more comfortable feeling. If they could, I am sure it will make a huge difference and would be appreciated by most patients.

Majors:

I have spoken to Doctor Mayosh, Doctor Loukas, Sister Jackie, Sister Phillipa and apart from a complaint about on average 3 to 10 patients being kept on beds in Majors overnight, they have no problems. In fact there is a general feeling of satisfaction and good in Majors, which is the result of everything having got better over the last two to three months.

I have spoken to Chris Friend, a discharge co-ordinator, about the above problem. While she thought that the discharge arrangements had improved immensely over the last few months, because of increased co-operation from social services and care home proprietors, she had no answer to the overnight bed problem and she referred me to Dai Davies.

I had a long conversation with Dai Davies and he has no solution either, except to have more beds on the wards for people to go to. He told me that WHH has 540 beds, and proportionally with QEQM, that number is far too low because their population numbers are double that of QEQM.

I do hope that you find this Report useful and you can accept its conclusions and will make the necessary changes as soon as possible for the benefit of everybody working or attending William Harvey Hospital.

David Cooper
13th. September 2002.