The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

Royal Bournemouth Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

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Overall summary

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust provides healthcare for the residents of Bournemouth, Christchurch, East Dorset and part of the New Forest. It serves a population of around 550,000, and this rises during the summer. Some specialist services cover a wider catchment area, including Poole, the Purbecks and South Wiltshire.

The trust has two main locations: Royal Bournemouth Hospital and Christchurch Hospital. These are located about three miles apart on the South Coast. Most of the acute services are provided at Royal Bournemouth Hospital.

The trust has been inspected five times by CQC since it was registered in October 2011. It was in breach of the Health and Social Care Act 2008 in relation to the management of medicines in September 2011, but this was resolved in May 2012.

At the inspection in October 2013, children's care, midwifery, critical care and end of life care services at the hospital were good. (The children's service is limited to eye operations and the maternity service is a small midwifery-run unit.) In all services across the hospital, most staff were committed to the trust and eager to give good care to patients. Patients were complimentary about the care they received and the professionalism of staff on surgical services.

However, a number of services were not always safe, effective, responsive, caring or well-led. In particular we found that medical care (including care older people's care) was inadequate. There were widespread and significant negative views from patients and staff. The trust's Board had not focused sufficiently on improving or recognising these failures, or the urgent need to improve patient care. Other services requiring improvements to patients' experience included A&E, surgical services and outpatients.

We were told about basic nursing care not being given to patients, in particular on medical care Wards 3 and 26. We heard about a patient who had had fluids and food restricted in error. We also heard from five patients who told us they had been left to wet or soil their beds.The hospital had a high occupancy rate and there had been ongoing use of escalation beds when a ward or unit was full. This was dangerous and could not meet any patient's needs.

The trust did not at this time employ enough staff, even though it was fully aware that nearly all its beds were occupied all the time. We were told that there were 135 nursing and healthcare assistant vacancies at the end of September 2013. While 65 posts had been filled by late October 2013, the benefit to existing staff had not yet materialised, in particular for medical services. Some patients were still not receiving the care they needed in a timely manner, and there was an ongoing high risk of this continuing.

Patients who had suffered a stroke did not always have the fast access urgent treatment on the specialist unit that they needed.

Other issues we found were:

- Care planning and evaluation did not always contain all relevant information, and staff on duty did not always know the specific care needs of people.
- Mandatory training for staff was not always delivered on time, or they were not always suitably trained for the areas in which they might work, for example dementia care and assessing whether a patient is able to swallow.
- Security arrangements in A&E left staff feeling vulnerable.
- We found the trust overall was not ensuring effective leadership and governance across the hospital.

At the follow up inspection in August 2014, we found that significant improvements had been made and the issues found in October 2013 had been addressed.

The trust had agreed a two year organisation development plan with a focus on improving quality. A revised organisational structure was being implemented, with a strong emphasis on clinical leadership. This was supported by leadership training for all levels of staff. The governance systems had been strengthened at all levels and the Board members and senior management team were receiving more robust assurance of quality in all areas. We found there had been significant steps towards

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creating an open , transparent and learning culture at all levels of the organisation. The complaints policy and processes had been reviewed and the Trust was working more closely with local Healthwatch and patients to listen to their views and experiences, in order to make improvements.

The introduction of an Elderly Care Directorate with new assessment ward and pathways had improved the care for older people and the flow of patients through the hospital.

The unsafe escalation beds were no longer in use.

We found increases in staffing levels and increased support for junior doctors. The appointment of clinical matrons and support for ward sisters to focus on leadership and supervision of staff on the wards now supported planning and the delivery of safe and effective care. The speed of access to diagnostics and the stroke unit had improved, but the trust still needed to review the out of hours medical cover to ensure these patients had access to timely specialist assessment and treatment once on the Stroke Unit.

Improvements on A&E included improved security arrangements. We found evidence of training having a positive impact on patient care, particularly for those living with dementia. The trust was aware of the need for more robust patient pathways for some patients admitted to A&E and was in discussion with Commissioners and local NHS partners to make those improvements.

Staff were proud of the improvements achieved since the last inspection but recognised there was more to be done to ensure the changes were embedded and the quality of services sustained.

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

At the previous inspection in October 2013 we found that care at the hospital was not always safe. We had particular concern about some medical wards, including for frail older people, surgical wards, A&E and outpatients. However the services that were safe included maternity, critical care, children's care and end of life care.

At the follow up inspection in August 2014 we found that the trust had taken steps to address the concerns in these areas. The services were following better safety procedures. Both medical and nursing staffing levels had increased on the wards and recruitment was on-going. The trust had strengthened clinical leadership and seven day working of senior staff, to support the delivery of safe care.

The trust had improved the management of the flow of patients through the hospital, so was not running at over- capacity and the unsafe escalation beds were no longer in use.

The trust was committed to ensuring that everyone in the hospital took accountability for providing safe care. The trust has developed stronger mechanisms for identifying and responding to the indicators of the risk of unsafe care.

Are services effective?

At the previous inspection in October 2013 we found many parts of the hospital were effective and applied recognised clinical guidelines or national standards to deliver treatment that met patients' needs. However the A&E and medical care services were not effective. Also there was a need to ensure greater external scrutiny of some measures, for example mortality rates.

At follow up inspection in August 2014 we found that improvements had been made to A&E and medical services. The trust had engaged external specialist advice to review clinical teams and make changes to models of care against national best practice. In particular, the creation of the elderly care directorate and in the review of mortality outliers.

There had been some improvements to the stroke pathway, so that patients were getting more timely access to the Stroke Unit. But further work was still required towards achieving national standards.

Are services caring?

At the previous inspection in October 2013, patients, their relatives and staff told us about incidents where patients had not been treated with dignity and respect. Some aspects of care were not met

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in a timely manner. This was found to be inadequate on medical care Wards 3 and 26 in particular and, although to a lesser extent, across medical services as a whole. However, there were many positive examples of caring in areas that included maternity, critical care, children's care, outpatients and end of life care.

At the follow up inspection in August 2014 we found that all services we visited were caring.

We found some exceptional examples of care and attention provided by staff at all levels and disciplines across the organisation.

The trust had taken steps to ensure that patients received timely care and that they and their relatives were treated with dignity and respect.

Are services responsive to people's needs?

The inspection in October 2013 found children's care, critical care and end of life care were particularly responsive to people's needs. However, improvements in one part of the hospital were not necessarily shared across all services. Services tended to work in isolation. We found people were able to raise concerns and make complaints. However some people felt that when they made a complaint, the trust was dismissive of their concerns. This meant that they either chose to have care elsewhere or continued to feel dissatisfied. A&E, medical services and outpatients were less responsive to the needs of patients.

Since then, the trust has taken steps to improve both the process and timeliness of response to concerns and complaints, at department as well as at trust level. We found initiatives to improve communication with and learning from patients and their relatives. At follow up inspection in August 2014 we found A&E, medical services and outpatients were now much more responsive to the needs of patients.

Are services well-led?

The inspection in October 2013 found children's care, maternity, critical care and end of life care were generally well-led. Many departments and wards had effective leadership. However, at that time, the A& E department required improvements and medical care services in particular were inadequate in this regard. While there was clear communication between the senior management and the trust's Board, this was less apparent for other staff. This was affecting staff morale and individual professional accountability for some staff.

Since that inspection, the trust has sought external advice and has taken significant steps to improve leadership and accountability across all services and at all levels of the organisation. At follow up

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inspection in August 2014 we found significant improvements in the leadership of the A&E department and medical services. There was a clear commitment to address the disconnect that had existed between some staff on the floor and the senior management and Board. This had a positive impact on staff morale

The trust has worked with staff, the public and patients to identify shared values. The Board has a clearer focus on improving and sustaining high quality care.

The trust is committed to a two year organisational development plan. A new organisational structure aims to enhance leadership capability and accountability across all services. This is being supported by leadership training for clinical staff at all levels of the organisation.

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What we found about each of the main services in the hospital

Accident and emergency

At inspection in October 3013 we found that the A&E service was not always safe and effective, because of the use of escalation beds and extra trolleys. Staff and patients were not fully protected from abuse because of the lack of robust security measures. Staff were caring about patients' needs, but were not always responsive. Patients with a stroke were not always given the urgent care they needed. A&E was well-led at department level, but there was evidence that the on-going safety issues had not been resolved at board level.

At follow up inspection in August 2014 we found that the safety and effectiveness of the A&E service had improved. The escalation beds were no longer in use. Access to diagnostics for stroke had improved. Staff and patients were better protected from abuse because of the increased security measures.

The multi-disciplinary team called OPAL (Older Persons Assessment Liaison) functioned out of the A&E department and provided specialist and highly effective interaction to those requiring complex discharge arrangements.

Staff were caring and compassionate about patients' needs, and we saw and heard some episodes of outstanding care.

The department was responsive to individual need. There were some challenges in timeliness of response for patients requiring, for example, specialist mental health interventions. However, this was due to the limited availability of local community mental health provision. The care pathway for children aged 16-17 years who required inpatient admission following attendance at the department needed to be more robust to ensure wholly safe and effective care and treatment. This care pathway was being reviewed with commissioners and Poole Hospital NHS Foundation Trust.

Medical care (including older people's care)

At inspection in October 2013 we found that the quality of patient care varied between the medical wards and units. The patient experience was worse on Ward 3 and Ward 26 than the rest, although there were concerns throughout due to staffing levels. Some patients told us that they felt their care had not been delivered in a safe and dignified way. Some had concerns about the numbers of nurses on the wards and felt that their care had been compromised by a lack of staff. We heard about a patient who had had fluids and food restricted in error, and some had not been

treated with dignity and respect. We found examples of incidents that staff had not reported through the reporting system. Staff told us they were fearful of the high bed occupancy and the pressure this placed on them.

At follow up inspection August 2014 we found improvements had been made. Patients were happy with the care and treatment they received. They felt the care was safe, there were sufficient staff and they were treated with respect and dignity. Staffing levels had been reviewed, and the staffing levels had been increased in line with the dependency and acuity of patients on the wards. New staff had been recruited and where there were still vacancies, block booking of agency staff had ensured the staffing numbers were generally maintained.

Shortfalls in recording of care and undertaking of equipment checks were being addressed. Training and support for staff was provided and records were being audited daily. Patients with dementia received good care with staff routinely receiving training about caring for patients with dementia.

Data showed the trust to be below the national averages in five out of ten areas of stroke care. For patients admitted into hospital with a stroke, the availability of specialist consultants and nurses meant it could not be assured they would be seen by a stroke consultant and stroke nurse within 24 hours. This was not in line with national benchmarking and had the potential to compromise their care and potential recovery. The data also showed the trust to be below the national for CT scans completed in one hour and in 12 hours and for thrombolysis treatment to be started within one. However the Trust was now meeting the nation averages for admission and thrombolysis treatment within four hours.

Discharges from hospital were well planned, and discharge planning now started on admission to the hospital Action was being taken to reduce the number of delayed discharges that occurred because of delays in home care arrangements being set up.

Staff were positive about the new management structure for the Directorate. They felt supported by both their managers and their senior managers.

Surgery

The inspection in October 2013 found the safety of patients could be improved. We saw that staff were very busy and although patient care was safe, staff told us that they often worked with fewer staff than was needed. Staff told us they found this stressful and that sometimes patients had to wait for their care.

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At follow up inspection in August 2014 we found the safety of patients had improved. Staff told us that there had been a nurse recruitment drive and there were now more staff on the wards than before. They also told us that response to patients had also improved. We spoke to patients and their relatives who told us that nurses responded to their needs in a timely manner.

The trust had further embedded a system for identifying the number of nurses required on the ward. As a result, the numbers of nursing staff had increased. At the previous inspection in October 2013 we found that junior surgical doctors were not well supported overnight and the medical staff handovers of information at the change of shift were not sufficient to ensure safe practice. At follow up inspection, in August 2014, junior surgical doctors told us they were well supported by senior doctors. The trust had taken action on staffing levels for nursing and medical staff. .

We saw that staff worked effectively and collaboratively to provide a multidisciplinary service for patients in their care. When patients needed care from several specialities of the hospital, this was done effectively to ensure the patients were well cared for.

We found staff were caring and the service responded to patients' needs. Patients were complimentary about the care they received and the professionalism and courtesy of staff. They told us that the service met their needs and that they felt well cared for by the nursing and medical staff.

Surgical services now had clear leadership and there were improvements since our last inspection October 2013. The new nursing structure was getting well-embedded and the appointment of matrons provided clinical leadership within the department.

Intensive/critical care

At inspection in October 2013 we found the service was safe, effective, caring, responsive and well-led. We found that people were protected from the risks of infection, and changes to practice were made following learning from incidents. Care was planned and delivered to meet patients' assessed needs by staff that had appropriate skills and training. Patients were treated with dignity and respect and their privacy was maintained. Staff were aware of their roles and responsibilities and there was a clear leadership structure. However, patients were not always discharged promptly when they no longer needed intensive care.

Maternity and family planning

Inspection in October 2013 found that the midwifery unit provided safe and effective care for women with a low risk of developing complications during birth. Feedback from women using the service

was positive. They told us staff were exceptionally caring and helpful. The service was well-led. Women said they had been well supported throughout their stay in the unit. Improvements could be made where access to scans is limited.

Women using the midwifery-led maternity service can be assured of a good standard of care during their pregnancy and birth, and be confident that that they will be supported in their chosen method of feeding their babies.

Services for children & young people

Only children's eye surgery is carried out at the hospital. At inspection in October 2013 we found the Children's Eye Ward provided safe and effective care for children who had undergone ophthalmic surgery. Feedback from patients and their families was positive. They told us the service was very oriented to the care of young people. For example, colouring books were routinely offered during outpatient appointments.

The service was well-led and responded appropriately to the needs of the children. Children requiring ophthalmic surgery at the hospital can be assured of a good standard of care and their families can be confident that that they will be supported during their child's stay in hospital.

End of life care

Inspection in October 2013 found end of life care services in the hospital were safe, effective, caring, responsive and well-led. Improving end of life care had been a high priority over the last 12 months and good progress had been made on a number of important new initiatives. This included implementation of new personalised care plans for last days of life.

Our conversations with patients, their relatives and care staff provided evidence of good quality care and treatment. Patients and their relatives told us they were fully involved in care planning decisions and were regularly updated on changes in the patient's condition. All the staff we spoke with were knowledgeable, passionate and committed to providing high quality care for patients at the end of life and their families.

Outpatients

At inspection in October 2013 we found the outpatients department generally provided a caring and effective service for patients. There was much praise for the dedication of the staff. Feedback from patients was positive. The trust had not, however, been responsive about issues with waiting times and communication.

Individual clinics were well-led, with clinical staff taking responsibility for the organisation and arrangements as needed.

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However, quality assurance and risk management to ensure safety was not always supervised appropriately. There were infection control risks in the environment and staff were not clear about the measures in place to monitor infection control standards in the outpatient areas throughout the hospital.

At inspection in August 2014 there had been significant progress since our last inspection. We found that the trust had been responsive about issues with waiting times and communication. It had implemented a quality assurance and risk management system to ensure safety of patients. Infection control risks had been minimised by better cleaning rotas. The sluice room was de-cluttered and there were measures put in place to monitor infection control standards in the outpatient areas.

Summary of findings

What people who use the trust's services say

Analysis of data from the CQC's Adult Inpatient Survey between September 2013 and January 2014 indicated that the trust scored within the expected range for all areas.

The Friends and Family Test (FFT) score is the proportion of respondents who would strongly recommend minus those who would not recommend, or who are indifferent. This gives a score between –100 and 100. In June 2014, the trust scored 72, the same as the national average score on the Inpatient Friends and Family Test, and 75 above the national average for A&E. However, the response rate was low.

On the trust's section of the Patient Opinion website patients generally viewed the hospital as performing well and regularly praise the staff.

At inspection in October 2013 we received negative feedback from patients and relatives about the quality of care, privacy and dignity particularly for older frail patients on medical wards.

At the follow up inspection in August 2014 we spoke to 20 patients and relatives on the medical elderly care wards. The feedback on their experience was overwhelmingly positive.

As part of the inspection in August 2014 we received 75 comments cards from across medical and surgical wards and the outpatient department. All but three were positive about their experience of the services and the care and treatment received. The three negative comments related to staff attitude and experience of the hospital at night. We saw that some wards had started initiatives to improve patient experience at night, as they had received similar feedback.

Areas for improvement

Action the trust MUST take to improve

We had set compliance actions following inspection in October 2013. At follow up inspection August 2014 we found these compliance actions had been met as follows:

- All patients need to have their needs assessed and care delivered safely and in a timely manner by staff who are skilled to do so. At follow up inspection August 2014 we found on-going improvements to the assessment, planning and delivery of care. This was supported by the appointment of clinical matrons and practice development nurses.
- At all times, patients must be treated with the dignity and respect they deserve and basic care needs must be met. At follow up inspection August 2014 we found action had been taken and patients were treated with dignity and respect and receiving care that met their needs.
- The trust must reassure itself and stakeholders that all opportunities to drive quality improvement and quality assurance are taken. At follow up inspection in August 2014 we found a clear commitment to quality improvement at all levels of the organisation and more robust quality assurance processes.
- The trust must ensure that the required number of staff with the correct skills are employed and managed shift by shift, to demonstrate that there are sufficient staff to meet people's needs. At follow up inspection in August 2014 we found the trust had taken significant steps to recruit sufficient staff and this was an on-going commitment.

Action the hospital COULD take to improve

At inspection in October 2013 we identified actions the trust could take to improve. At inspection August 2014 we found the following actions had been taken:

- The stroke pathway before patients are admitted to the stroke ward. At follow up inspection in August 2014 we found this action had been met, through the

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introduction of a more streamlined stroke pathway. However, the provision of specialist medical assessment and treatment of stroke patients admitted to the stroke ward out of hours could be improved.

- Levels of nursing staff in wards, especially those caring for the frail elderly patients, did not reflect the dependency of patients. This meant there was a high risk and actual occurrences of patients not receiving the care they needed in a timely manner. At follow up inspection August 2014 we found the trust had taken steps to monitor staffing levels in relation to the dependency of patients. Additional staff were provided when required to meet the needs of patients.
- Care planning and evaluation did not contain all relevant information and staff on duty did not always know the specific care needs of people. At follow up inspection August 2014 we found some improvements and monitoring of care planning, along with support for newly recruited staff.
- Staff had not all attended mandatory training within the stated timeframe and/ or were not suitably trained for the areas in which they may work, for example, in dementia care, and to perform the necessary tests to assess whether a patient is able to swallow. At follow up inspection August 2014 we found that staff had attended appropriate training. Support from Clinical matrons and practice development nurses, and more clinical time for ward sisters provided support for staff in developing the necessary knowledge and skills.
- Security arrangements in A&E previously left staff feeling vulnerable. At follow up inspection August 2014 we found more robust security arrangements in place, although staff wanted continued consideration of developing an in-house security team.
- Escalation beds in AMU and A&E were considered dangerous and not fit for purpose. At follow up inspection in August 2014 we found that escalation beds were no longer used.
- Junior medical staff in surgical services required more support out of hours. At follow up inspection August 2014 we found actions had been taken and junior medical staff were well supported.
- Patients did not always have informed consent by doctors who were fully aware of procedures. At follow up inspection August 2014 we found actions had been taken and improvement in staff understanding.
- The mental health care pathway in A&E was not a 24-hour service. At follow up inspection August 2014 we found actions to address this had been taken since the last inspection. However a pilot of additional mental health support was no longer funded and the pathway could be improved yet further..
- A&E did not always provide care for children from suitably-qualified staff at all times. At follow up inspection August 2014 we found actions had been taken to recruit more staff. However, the trust continued to have some concerns about admitting patients aged 16-17 years as there was not inpatient paediatric support at the hospital.
- Records for care and for incidents were not always completed in full and timely manner. At follow up inspection August 2014 we found appropriate actions had been taken and there was on-going monitoring and support provided to improve the accuracy of records.
- The outpatient booking process was not always patient-focused and sometimes led to patients experiencing long waiting times. At follow up inspection August 2014 we found actions had been taken to reduce unnecessary waits.

At inspection in August 2014 we found the trust SHOULD take the following actions to further improve:

- The trust should increase privacy for patients in A&E Majors department by providing frosted glass or privacy film to the externally facing windows in cubicles.
- The trust should take action to improve the service for stroke patients in line with national benchmarking for stroke patients, particularly for those patients admitted at weekends or out of hours.
- The trust should ensure that for patients who require their fluid intake and/or output to be monitored that this is accurately recorded.
- The trust should ensure that the records of checks of essential equipment are accurately and consistently recorded on ward areas.
- The Alzheimer's Society booklet 'This is Me' should be completed for patients living with dementia.
- The trust should take action to improve the mental health care pathway in A&E which is not yet a 24-hour service.

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- The trust should work with commissioners to clarify admission criteria and suitable locations for 16-18 year olds requiring admission to hospital from the A&E department.
- The trust A&E department should consider a more robust checking procedure of ensuring that transfer equipment is routinely returned to its' base and left in a clean and charged condition ready for immediate use when necessary.
- The trust should take action so that nursing staff who have the skills to provide an outreach stroke service to patients on other wards of the hospital are able to provide this service.
- The availability and visibility of hand cleansing gel in the outpatient department should be improved.

Good practice

Our inspection team highlighted the following areas of good practice in October 2013:

- Some aspects of end of life care were undertaken very well.

Our inspection team highlighted the following areas of good practice in August 2014:

- The multi-disciplinary team called OPAL (Older Persons Assessment Liaison) provided specialist and highly effective support to those requiring complex discharge arrangements.

Royal Bournemouth Hospital

Detailed findings

Services we looked at:
Accident and emergency; Medical care (including older people's care); Surgery; Outpatients

Our inspection team

Our inspection team was led by:

Inspection October 2013:

Chair: Dr Michael Anderson, Consultant Gastroenterologist

Team Leader: Joanne Ward, Care Quality Commission

The team of 22 included doctors, nurses, senior managers, other clinical specialists, CQC inspectors, patient representatives and Experts by Experience. Experts by Experience have personal experience of using or caring for someone who uses this type of service.

The follow up inspection August 2014:

Team Leader: Anne Davis, Care Quality Commission

The team of nine included an elderly care/stroke consultant a surgeon, nurses, CQC inspectors and an Expert by Experience. Experts by Experience have personal experience of using or caring for someone who uses this type of service.

Why we carried out this inspection

We inspected this trust in October 2013 as part of our new in-depth hospital inspection programme. Between September and December 2013, we used the new approach at 18 NHS trusts. We chose these trusts because they represented the variation in hospital care in England according to our 'Intelligent Monitoring' information. This looks at a wide range of data including patient and staff surveys, hospital performance information and the views of the public and local partner organisations. Under this model, The Royal Bournemouth and Christchurch Hospital NHS Foundation Trust was considered to be a high risk service.

The inspection August 2014 was to follow up areas for improvement found at the inspection in October 2013.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

October 2013

The inspection team inspected the following core services:

- Accident and emergency (A&E)
- Medical care (including older people's care)
- Surgery
- Intensive/critical care

Detailed findings

- Maternity and family planning
- Children's care
- End of life care
- Outpatients.

The lines of enquiry for this inspection were informed by our Intelligent Monitoring data. As part of the inspection process, we contacted a number of key stakeholders and reviewed the information they gave to us. We received information from people who use the services, the medical royal colleges, Monitor, Dorset Clinical Commissioning Group and Health Education England. We carried out an announced inspection visit on 24 and 25 October 2013. We looked at the personal care or treatment records of people who use the service, and we observed how staff cared for patients and talked with people who use the services. We talked with carers and family members. We held seven focus groups with staff. We talked to and interviewed a range of staff including the Chairman, Governors, Chief Executive, Medical Director and Director of Nursing. We also carried out an unannounced inspection visit on 30 October 2013. We placed comments boxes around the hospital and received more than 30 comments from people who used the service and staff. We held a public listening event in Bournemouth on the evening of 24 October 2013. Around 85 people talked to us about their experiences and shared feedback on how they thought the trust needed to improve.

August 2014

The inspection team inspected the following core services to follow up concerns found at previous inspection:

- Accident and emergency (A&E)
- Medical care (including older people's care)
- Surgery
- Outpatients.

The lines of enquiry for this inspection were informed by the findings of our previous inspection in October 2013 . As part of the inspection process, we contacted Healthwatch Dorset and reviewed the information they gave to us.

We carried out an un announced inspection visit on 13 and 14 August 2014, plus an unannounced evening visit to A&E on12 August. We looked at the personal care or treatment records of people who use the service, and we observed how staff cared for patients and talked with people who use the services. We talked with carers and family members. We talked to and interviewed a range of staff including the Chief Executive, Chief Operating Officer, Medical Director and Director of Nursing.

We placed comments boxes around the hospital in areas related to medicine, care of older people, outpatients and received more than 75 comments from people who used the service along with some comments from staff.

Are services safe?

Summary of findings

At the inspection in October 2013 we found that care at the hospital was not always safe. We had particular concern about some medical wards, including for frail older people, surgical wards, A&E and outpatients. However the services that were safe included maternity, critical care, children's care and end of life care.

At follow up inspection in August 2014 we found that the trust had taken steps to address the concerns in these areas. The services were following better safety procedures. Both medical and nursing staffing levels had increased on the wards and recruitment was on-going. The trust had strengthened clinical leadership and seven day working of senior staff to support the delivery of safe care.

The trust had improved the management of the flow of patients through the hospital, so was not running at over capacity and the unsafe escalation beds were no longer in use.

The trust was committed to ensuring that everyone in the hospital took accountability for providing safe care. The trust has developed stronger mechanisms for identifying and responding to the indicators of the risk of unsafe care.

Our findings

In October 2013 we found that the service were safe in the smaller services of midwifery services, children's care and critical care, and also for end of life care where accessed. We found safety concerns in medical wards, particularly those for the frail elderly, A&E, surgical services and outpatients.

At follow up inspection in August 2014 we found that medical (including elderly care), surgical, A&E and out patients services were safe.

The trust had taken steps to improve patient flow through the hospital and remove the unsafe escalation beds in the Acute Medical Unit (AMU). This had been achieved through a number of initiatives in A&E, the extension of rapid assessment clinics and good use of the Older Persons Assessment Liaison (OPAL) team to facilitate discharge home. The trust had established a new Elderly Care Directorate and a new short stay elderly care assessment unit. The trust had recruited additional consultants in A&E, AMU, care of the elderly and surgery. Weekend consultant ward rounds and seven day working of the multi disciplinary team had reduced the pressure on beds and supported appropriate and safe care for patients.

Security, to keep patients and staff safe in A&E, was much improved. We also found improvements had been made to ensure timely access to scans for stroke patients in A&E. However access to specialist medical care was inconsistent for patients admitted to the stroke ward out of hours and weekends, as there was not a designated team to cover these periods.

The trust had taken significant steps to increase numbers of nurses through recruitment of nurses from overseas. There was a 5% vacancy rate across all specialities and this was greater in the elderly care directorate. But this was mitigated by block booking of agency staff and trust bank staff to provide continuity of care until more full time staff were in post. Recruitment was on-going and 32 newly qualified nurses were due to start in September 2014. Staffing levels and skill mix were monitored on a daily basis by the Director of Nursing. We found staff were confident that where they found a need for additional staffing, or raised safety concerns, then this would be addressed.

A recent organisational restructuring had strengthened clinical leadership across the trust but particularly in the elderly care directorate. Ward sisters were provided with administration support to facilitate more time supervising and ensuring safe care on the wards. Matrons and practice development nurses were appointed to provide supervision and support to ensure competency of staff and of safe care. This was particularly important for newly qualified staff and those from overseas.

The 'Safety Thermometer' continued to be used to monitor and promote patient safety. The trust was working to halve the number of pressure ulcers, falls, venous thrombo embolism (VTE) and urinary infections for patients with catheters. Figures showed that pressure ulcers and falls were reducing trust wide, VTE and catheter infections were low in number and the trust had targets to reduce to at least half the number last year. The trust had introduced bay based nursing which increased staff presence in patient areas and this correlated with a reduction in patient falls. The trust was taking proactive steps to reduce the

Are services safe?

incidence of pressure damage, as numbers of pressure ulcers had been consistently high. Newly purchased pressure relieving mattresses were being introduced as standard across all high risk ward areas.

We found that staff reported accidents or incidents and these had been reviewed by the hospitals patient safety and governance department. An online incident reporting system had been introduced which would provide greater analysis and identification of trends. The trust had strengthened systems for monitoring patient safety 'ward to board' and was continuing to review and improve the metrics used in the Trust Quality Dashboard to identify risks of unsafe care. We saw examples of the early identification of indicators of poor leadership and unsafe care on a ward and timely actions to address this.

Are services effective?

(for example, treatment is effective)

Summary of findings

The Inspection in October 2013 found many parts of the hospital were effective and applied recognised clinical guidelines or national standards to deliver treatment that met patients' needs. However the A&E and medical care services were not effective. Also there was a need to ensure greater external scrutiny of some measures, for example mortality rates.

At follow up inspection in August 2014 we found that improvements had been made to A&E and medical services. The trust had engaged external specialist advice to review clinical teams and make changes to models of care against national best practice. In particular in the creation of the elderly care directorate and in the review of mortality outliers.

There had been some improvements to the stroke pathway, so that patients were getting more timely access to the Stroke Unit. But further work was needed towards achieving national standards.

Our findings

Prior to our inspection in October 2013 our information showed the trust had a higher than expected hospital standardised mortality ratio. The higher mortality rates were one of the factors that prompted the inspection. The trust had a consultant led Mortality Review Group established over a number of years with the aim of reviewing and learning from death rates. There was internal scrutiny of deaths however opportunities for a professional review by an external expert clinician had not been undertaken. Since the inspection in October 2013 the trust has engaged with another NHS trust to ensure external scrutiny of mortality outliers.

At inspection in October 2013 and August 2014 we saw that clinical guidelines were in line with national standards and applied and used by all staff in A&E. We found children attending A&E could not always be seen by specialist nurses, and whilst the A&E consultants are paediatric trained there was no consultant paediatrician on site as the hospital did not have a paediatric service.

In August 2014 we found the trust had made extensive efforts to recruit, and a new children's nurse was due to start in September 2014.

Patients requiring mental health assessment had to wait too long for the appropriate team from a neighbouring mental health trust to come to the department. Some action had been taken since the last inspection with a three pilot scheme to address the issues, but this was no longer funded by the time of the follow up inspection.

At the inspection in October 2013, we heard concerns from patients and relatives who felt that they had not received good treatment as a result of staff not being trained to meet with their specific needs. At the follow up inspection in August 2014 we found the trust had taken steps to ensure that training and support for staff was provided and records were being checked daily. Patients with dementia received good care with staff routinely receiving training about caring for patients living with dementia.

At previous inspection in October 2013, the trust was not in line with national expectations for stroke patients prior to admission to the stroke ward. All data showed the trust to be far below the national averages.

In August 2014 we found improvement in some but not all areas. Data showed the trust to be below the national averages in five out of ten areas of stroke care. Patients admitted into hospital with a stroke could not be assured they would be seen by a stroke consultant and stroke nurse within 24 hours. The data also showed the trust to be below the national for CT scans completed in one hour and in 12 hours and for thrombolysis treatment to be started within one. However the trust was now meeting the national averages for admission and thrombolysis treatment within four hours.

Are services caring?

Summary of findings

At the previous inspection in October 2013 patients, their relatives and staff told us about incidents where patients had not been treated with dignity and respect. Some aspects of care were not met in a timely manner. This was found to be inadequate on medical care Wards 3 and 26 in particular and, although to a lesser extent, across medical services as a whole. However, there were many positive examples of caring in areas that included maternity, critical care, children's care, outpatients and end of life care.

At the follow up inspection in August 2014, we found that all services we visited were caring.

We found some exceptional examples of care and attention provided by staff at all levels and disciplines across the organisation. The trust had taken steps to ensure that patients received timely care and that they and their relatives were treated with dignity and respect.

Our findings

At inspection in October 2013 we found some positive examples of caring services.

One woman who had recently given birth in the midwifery run unit told us "It's been amazing; the care has been brilliant, so attentive." They told us that they had planned to give birth in the unit and had been well supported throughout their stay in the unit.

Children requiring ophthalmic surgery at the Royal Bournemouth Hospital received a good standard of care during their stay and their families were supported during their child's stay in hospital.

In Critical Care we found that patients were treated with dignity and respect and their privacy was maintained.

End of life care services had been a high priority and good progress had been made on implementing a number of important new initiatives. This included implementation of new personalised care plans for last days of life. Our conversations with patients, their relatives and care staff provided evidence of good quality care and treatment. Patients and their relatives told us they were fully involved in planning decisions and were regularly updated on changes in the patient's condition. All of the staff we spoke with were knowledgeable, passionate and committed to providing high quality care for end of life patients and their families.

However, some people told us very concerning stories of their experiences and how the trust had not cared about them or their relatives and where privacy and dignity had not been respected. We found improvements were needed on medical wards and in particular the care of frail elderly patients on wards 3 and 26.

At follow up inspection in August 2014 we found significant improvements. The feedback from patients and relatives we spoke with on the wards, A&E and outpatients departments was overwhelmingly positive about the caring attitude of staff.

We received 75 comment cards, the majority were very positive about caring services. There were a small number of comments about uncaring attitude of some staff on some wards at night and these were passed to the Director of Nursing. Some wards had started an initiative to improve patient experience at night based on feedback they had received.

We observed many examples of good care and positive interactions between staff and patients. Privacy and dignity was promoted in all areas we visited.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The inspection in October 2013 found children's care, critical care and end of life care were particularly responsive to people's needs. However, improvements in one part of the hospital were not necessarily shared across all services. Services tended to work in isolation. We found people were able to raise concerns and make complaints. However some people felt that when they made a complaint, the trust was dismissive of their concerns. This meant that they either chose to have care elsewhere or continued to feel dissatisfied. A&E, medical services and outpatients were less responsive to the needs of patients.

Since then the trust has taken steps to improve both the process and timeliness of response to concerns and complaints, at department as well as at trust level. We found initiatives to improve communication with and learning from patients and their relatives. At follow up inspection in August 2014 we found A&E, medical services and outpatients were now much more responsive to the needs of patients.

Our findings

At inspection in October 2013, we found some positive examples of responsive services. The majority of end of life care patients were seen on the same day they were referred to the specialist palliative care team or to the facilitator. At weekends and out of hours, advice was available from the specialist palliative care unit at Christchurch Hospital.

Medical and nursing staff spoken to on the wards all said they had good access to the consultant in palliative medicine, the specialist palliative care nurses and the facilitator. The trust had a shared consultant on-call rota with the specialist palliative care unit at Poole Hospital enabling 24 hour cover at all times. This helped ensure a responsive service was available at all times.

Staff explained how they could access interpreters when required for people whose first language was not English, but they told us this was sometimes a challenge due to time constraints. Staff told us how they had supported people from different cultures such as East European and Middle Eastern areas.

The safeguarding children's lead told us that the trust had improved awareness of the service it offered infants, children and adolescents as on investigation it was found that most of the departments in the hospital had dealings with children. They gave the examples of services from emergency care and radiology to dermatology and orthodontics that saw and treated children on a regular basis.

We were told that the design of the local maternity services throughout Bournemouth, Poole and Dorset had been subject to public consultation.

The trust was often below the national target for waiting times in A&E for patients being admitted or discharged or transferred in four hours. Since May 2013 the trust has met or exceeded the target. However patients were moved within the same environment such as to an observation bay, cared for by the same team and are at this point an inpatient.

We found there were a number of patients unable to be discharged due to delays. At follow up inspection, we found that the discharge processes for patients now began as soon as they were admitted to the wards and the flow of patients through the hospital had improved.

In October 2013 we found that whilst the trust had an open approach to making a complaint people told us that they did not feel listened to. Several were overwrought with their despair at the way the trust had responded to them and some felt that the trust were dismissive and so they chose to have care elsewhere.

At follow up inspection in August 2014 we found the trust had reviewed the complaints policy and procedure following external review and wide consultation. There had been learning from complainant focus groups. There was now an emphasis on faster response to complaints through a phone call from the most appropriate person or department. There was also a focus on improving communication, for example by avoiding clinical terminology. The trust used complaints and patients stories for learning and improving services, for example at staff meetings, training sessions for junior doctors and Board meetings.

Every ward displayed the positive and negative feedback from their monthly patient and family survey and what had been done in response to that feedback.

Are services responsive to people's needs?

(for example, to feedback?)

We found improvements in waiting times and communication for patients in outpatients.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Summary of findings

The inspection in October 2013 found children's care, maternity, critical care and end of life care were generally well-led. Many departments and wards had effective leadership.

However the A& E department required improvements, and medical care services in particular were inadequate in this regard.

While there was clear communication between the senior management and the trust's Board, this was less apparent for other staff. This was affecting staff morale and individual professional accountability for some staff.

Since the inspection in October 2013 the trust has sought external advice and has taken significant steps to improve leadership and accountability across all services and at all levels of the organisation. At follow up inspection in August 2014 we found significant improvements in the leadership of the A&E department and medical services. There was a clear commitment to address the disconnect that had existed between staff on the floor and the senior management and Board. This was having a positive impact on staff morale.

The trust had worked with staff, the public and patients to identify shared vision and values. The Board had a clear focus on improving and sustaining high quality care.

The trust is committed to a two year organisational development plan. A new organisational structure aims to enhance leadership capability and accountability across all services. This is being supported by leadership training for clinical staff at all levels of the organisation.

Our findings

At the inspection in October 2013 we found that, in particular, the smaller services such as midwifery , children's care, critical care and end of life care were well-led.

We found the A&E was well-led at department level, but there was evidence that the ongoing safety issues, such as staff security, had not been resolved at Board level. Staff had been told not to report incidents if the police were called to attend the unit.

Medical care services lacked effective leadership to identify and address issues. Some issues of inadequate care were well-known, for example those on Ward 3 and Ward 26 raised from staff feedback and patient complaints earlier in the year. These had still not been resolved by the time an external review they had commissioned took place in September 2013, or by the time of our inspection in late October 2013.

Surgical wards and theatres appeared well-organised and well-led. There were regular staff meetings to feedback updates and changes on the wards. We saw that governance arrangements were in place. Staff told us they mostly felt communication was good and that they were able to access updates if needed. However we found junior doctors on the surgical wards could go their entire shift without speaking to another doctor. This was not consistent with how medical services were managed elsewhere in the hospital.

The trust confirmed that the Board level executive with lead responsibilities for safeguarding children was the Director of Nursing and Midwifery and that there were named healthcare professionals with safeguarding children responsibilities and a nominated safeguarding children lead. There were suitable arrangements in place to safeguard children and young people from the risk of abuse.

We found that the hospital had systems in place for monitoring incidents and accidents and that these systems allowed staff to analyse data to look for trends that could help them to improve patients' safety. We were shown examples of where this had changed practice. However, we found examples of incidents that had not been reported by staff through the reporting system.

At follow up inspection in August 2014 we found the Board and senior management had taken actions and made significant improvements in response to the CQC inspection report. The Board now had a clear focus on improving quality and creating an open and transparent culture across the organisation. We found this vision was shared by staff in all the areas we visited. In general staff

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

morale had improved and there was higher expectation that their views and concerns would be heard and addressed. Steps had been taken to improve staffing levels and clinical support for nurses and junior doctors.

The trust had developed and started to implement a two year operational development plan. At the time of inspection an organisational restructuring was underway with the aim of strengthening leadership at all levels of the organisation. We found stronger clinical leadership in all the areas we visited and this was supported by planned or on going leadership training for clinical staff at all levels of the organisation.

Governance and assurance processes had been strengthened and we saw that the Board used a range of mechanisms for reviewing information on the quality of services being provided. The quality metrics and reporting systems were regularly reviewed and we saw examples of the identification of early warning triggers of poor care that enabled timely intervention. The Healthcare Assurance Committee minutes evidenced presentations from departments where there were indications of concern or where learning and improvements had occurred. We found that staff were more confident that reported incidents and concerns would be recognised and action taken.

In addition to reviewing quantitative performance data the executive team were taking individual responsibility for linking with specific service areas to gain assurance. Staff confirmed that the members of the executive team regularly visited wards and departments out of hours and at weekends when they were on call.

The trust had established trained inspection teams to visit departments as part of an internal review process to report on standards of care. The teams were made up of a variety of clinical and non clinical staff and included members of the Quality and Risk Committee. The executive team, including trust governors, took part in regular executive patient safety walk-rounds. One governor told us that, following the last inspection findings, they had changed their approach to reviewing quality on the elderly care wards. They reported positive engagement from departmental leads, medical and nursing, and positive timely response to the feedback from their visits.

We found many examples of the trust publishing and celebrating innovation and improvements in services and care. Staff were proud of the improvements achieved since the last inspection but recognised there was more to be done to ensure the changes were embedded and quality of services sustained.

Do not include in report

Accident and emergency

Information about the service

The Accident and Emergency (A&E) department provides 24 hour service seven days a week. It is known locally as the 'emergency department', with an attendance rate of approximately 70,000 patients a year. The department had two triage rooms, one paediatric room with two full time paediatric registered nurses, 10 minor cubicles (for less serious injuries), 13 major cubicles (for more serious injuries and illnesses) and a resuscitation room with three cubicles. There were also two four-bedded observation bays. The department worked closely with a 52-bed acute medical unit (AMU), which took GP referrals and has patients from A&E for up to 72 hours. The Royal Bournemouth Hospital does not receive any trauma or paediatric emergencies.

We visited the emergency department during the day on both 24 and 25 October and in the evening of 30 October 2013.

At follow up inspection we visited the department on the evening of 12 August and during the day on 13 and 14 August 2014. We spoke with patients and relatives as well as doctors, nurses, health care assistants and domestic staff. We talked to patients and staff about care, treatment and facilities and we also observed care being provided. We reviewed records during our visit.

Summary of findings

At inspection in October 3013 we found that the A&E service was not always safe and effective, because of the use of escalation beds and extra trolleys. Staff and patients were not fully protected from abuse because of the lack of robust security measures. Staff were caring about patients' needs, but were not always responsive. Patients with a stroke were not always given the urgent care they needed. A&E was well-led at department level, but there was evidence that the on-going safety issues had not been resolved at board level.

At follow up inspection in August 2014 we found that the safety and effectiveness of the A&E service had improved. The escalation beds were no longer in use. Access to diagnostics for stroke had improved. Staff and patients were better protected from abuse because of the increased security measures.

The multi-disciplinary team called OPAL (Older Persons Assessment Liaison) functioned out of the A&E department and provided specialist and highly effective interaction to those requiring complex discharge arrangements.

Staff were caring and compassionate about patients' needs, and we saw and heard some episodes of outstanding care.

The department was responsive to individual need. There were some challenges in timeliness of response for patients requiring, for example, specialist mental health interventions. However, this was due to the limited availability of local community mental health provision. The care pathway for children aged 16-17 years who required inpatient admission following attendance at the department needed to be more robust to ensure wholly safe and effective care and treatment. This care pathway was being reviewed with commissioners and Poole Hospital NHS Foundation Trust.

Accident and emergency

Are accident and emergency services safe?

In October 2013 we found A&E was not always safe for patients and staff.

At follow up inspection in August 2014 we found safety in A&E was now improved for patients and staff. The security arrangements for patients and staff had improved, the use of trolleys was tightly controlled for clinical reasons, and the staffing shortages had been actively addressed. There was not always systematic and rigorous checking of emergency and transfer equipment. For example, transfer monitors were not always plugged in after each use, and this was addressed during our inspection.

Security

On our previous inspection in October 2013, patients and staff were not fully protected from the possibility of verbal or physical abuse and there been a significant number of incidents.

At the follow up inspection in August 2014, we heard from staff and patients that the security on-site had much improved. There was an external security firm in place, and they responded quickly when called. However, staff in the department said that although this was satisfactory, they would prefer if the security staff belonged to the hospital to ensure they were trained in dealing with incidents in a consistent manner.

The reception staff told us they felt much safer with the new security screens in place. They said the security staff were on duty overnight and at weekends. The internal hospital porters still supported security, especially when security staff were busy with individual patients.

All A&E staff undertook mental health training and the correct use of de-escalation techniques. We observed one incident where a mental health patient awaiting assessment wished to leave the department unescorted. The nurse in charge reminded them of their responsibilities, and the situation was successfully de-escalated by an off-duty A&E doctor taking the patient outside for a cigarette break. This was a compassionate, appropriately considered and practical response.

We noted there was a loose seat in the back row of the reception area; it was possible that this could be used as a weapon. We informed the staff so they could deal appropriately with this.

Use of trolleys

We received information before the follow up inspection that extra trolleys were sometimes used in the majors treatment area down the middle of the department. These were in use during our inspection in August 2014. This did not give patients any privacy while feeling unwell or allow easy access to emergency equipment. However, staff monitored how long patients spent on the trolleys and, where possible, they moved patients on to a bed.

The department sister told us that people were always assessed on entry to the department. Therefore, patients requiring urgent nursing or medical interventions would not be placed in the middle of the unit. Although this situation was not ideal, it was a pragmatic short term solution which prevented patients being left in ambulances. In this way, they had the benefit of constant observation by nursing, medical and therapy staff whilst awaiting a bed.

Waiting times

The computer booking-in system tracked patients' waiting times. Staff showed us breaches of waiting times. At our previous inspection in October 2013, waiting times had been an unsafe issue and had been listed on the unit's risk register. At the follow up inspection in August 2014, the waiting times were being managed sufficiently and no-one had breached for non clinical reasons.

When we visited the department on the 13th August, some patients in the observation bays had been waiting for over four hours. Two of these patients required input from the Mental Health team, and their delay was caused by the considerable wait for assessment by this team external to the hospital. A third person was an elderly patient who had had a "failed discharge" when they had been returned to their care home the evening before. This was caused by difficulties at the care home, so the patient was transferred back to A&E where they had been nursed overnight whilst a new discharge plan was put safely into place.

Emergency equipment

At inspection in August 2014 we looked at the emergency equipment in the department. Staff had been trained to use it in line with their clinical job role. Doctors and trained

Accident and emergency

nurses had attended training in advanced life support (ALS) and paediatric advanced life support (PALS). Staff were confident of their role in a medical emergency situation and explained the department's procedures to ensure a quick response to an emergency bell.

The resuscitation trolleys were ready for use. They were always checked and re-stocked after use. They were not consistently checked daily by staff as we found some gaps on the checking lists.

In the paediatric area within minors treatment area, we saw a portable suction unit with no tubing attached. It was situated high on a shelf above the desk and was not immediately available to a member of staff. There was a possibility this could have been a hazard to a child standing by the desk as there was an electrical lead attached. This was moved when the staff were alerted to it. There were other suction units in the vicinity which could have been used in an emergency.

We found that transfer equipment, whilst mainly safe, was not consistently checked or plugged in after being returned to its' storage bay. For example, a blood pressure cuff was missing from a transfer monitor, and another monitor was not plugged in to re-charge.

We noted that an adult transfer bag had resuscitation drugs within it, and it was not sealed. There were a few items of unchecked articles in the paediatric transfer bag. Because these articles had had their packaging opened, it was not possible to state whether they were still within their expiry date.

In the observation bays, not all of the Yankauer suckers were appropriately covered.

After discussion with the unit Matron, checks and changes to ensure readiness and safety of emergency equipment were immediately instigated.

Escalation beds

The Acute Medical Unit (AMU) has 52 beds used for patients who require further medical assessment and treatment. At inspection in October 2013 we found the use of three 'escalation' beds overnight on AMU. These beds were in addition to the 52 bed places available and were placed in the middle of three separate bays. They did not have easy access to a call bell, oxygen or suction.

At follow up inspection in August 2014 we found that escalation beds had now been removed from this unit, as it was deemed unsafe practice because of lack of space and necessary emergency equipment access.

Staffing

At inspection in August 2014 we observed that despite being busy and moving patients through the department, staff were calm, compassionate and focused on patients' individual safety. They shared their work experiences with us and the problems they faced in a busy unit. They were passionate about their jobs and how the department had progressed and the plans they had to further improve.

We discussed staffing levels with the A&E Matron and with medical staff. The current nursing vacancy rate for the department was two healthcare assistants, five Band 5 staff nurses (with two newly appointed ones starting in September), four Band 6 junior sisters, and one Band 7 senior sister. The Matron told us there was a new Band 7 children's nurse due to start soon. There were also six Emergency Nurse Practitioners in post, some of whom had undergone specialist training to look after children and young people. This provided a level of specialist expertise within the Minor's department where most children were seen.

Bank staff were sometimes used to fill vacancies in A&E. These were nursing staff known to the department, and fully conversant with policies and procedures.The AMU used some agency staff whilst staff shortages were in place. The Deputy Director of Nursing told us this was a block contract to try to ensure that patients were looked after in a consistent manner.

During the days of the inspection, senior nursing staff were conducting interviews to appoint for the vacant posts at Band 6 level. The Matron told us she would also like to be able to appoint a nurse consultant /educator to the department to further strengthen the nursing team.

Medical staff told us the department had five full time consultants in post with one vacancy still to be filled. However, the Clinical Director told us since the last inspection a new ED consultant had been appointed. There was funding for 12 middle grade doctors and there were currently seven in post. There were no registrars working in the department. This meant that they were working with fewer doctors than required. However, staff told that this had not affected the care given to patients.

Accident and emergency

On the AMU there was a medical consultant on the ward to assess patients from 7pm to 10pm, which we were told improved care for patients. There was a consultant on call overnight to support staff.

Medical staff in A&E told us consultant cover at the weekend was not as good as they would like. They said the consultant on weekend duty had to attend Poole Hospital in the morning, then come to Bournemouth Hospital in the afternoon where they worked for approximately three hours. They said that this reduction in hours available to the hospital meant that this could result in a minor impact on the effectiveness of the department over the weekend hours.

Are accident and emergency services effective?
(for example, treatment is effective)

At inspection in October 2013 we found that services were not always effective. We found improvements at follow up inspection August 2014.

Waiting times were within reasonable parameters although the board in the waiting room did not always reflect an accurate state.

Children attending A&E could not always be seen by specialist nurses, and whilst the A&E consultants were paediatric trained there was no consultant paediatrician on site as the hospital did not have an inpatient paediatric service. However, the Matron had made extensive efforts to recruit, and a new children's nurse was due to start in September 2014.

The multi-disciplinary team called OPAL (Older Persons Assessment Liaison) functioned out of the A&E department and provided a high level of specialist interaction to those requiring complex discharge arrangements.

Patients requiring mental health assessment had to wait too long for the appropriate team from a neighbouring mental health trust to come to the department. Nevertheless, the staff in the department endeavoured to deliver appropriate and compassionate care.

Patient records were generally good, with a high compliance percentage of completed assessments.

Waiting times

At the previous inspection in October 2013, we noted that despite empty cubicles in the minor's area, patients were kept waiting in the waiting room for up to three hours and were bought in once a nurse was available for them. There was not a clear explanation given to patients waiting, and this caused some to become agitated. The follow up inspection in August 2014 demonstrated clear improvement in this area.

Patients arriving in A&E on foot were assessed promptly by the triage nurse. The triage nurse could request an X-ray, which helped to meet patients' needs in a timely manner.

We spoke with patients in the waiting room for minors and we were able to track them through to their treatment. These patients were happy with their care. Their feedback included, "It said four hours on the board, but we were seen quite quickly which was a nice surprise". Another family with a young child praised the reception and medical staff stating, "They put us at our ease immediately."

Caring for children

Children with minor injuries were seen, triaged and attended to by paediatric nurse practitioners. If it was a serious medical problem, a doctor was immediately consulted and ambulances were arranged to transfer the children to Poole Hospital. At inspection in August 2014 there were two full time paediatric nurse practitioners who provided specialist cover for six days a week. The seventh day was covered by the staff in minors. The paediatric nurse told us that holiday cover was not provided for them, so when one of them is on leave, four days of the week would not have an appropriate paediatric nurse on duty. This potentially placed children at risk of not having their needs met. However, to mitigate this potential risk, the Matron had made considerable efforts to recruit a senior member of nursing staff with a paediatric qualification. This person was due to start in a few weeks. All nursing and medical staff had undertaken an appropriate level of paediatric emergency training.

The Matron told us that child protection indicators had now been linked to the departmental electronic record system. This meant that children known to Social Services would flag on the system if they presented to the department. The department would like to employ a

Accident and emergency

Health Visitor to work with them on this issue, and a senior trust manager told us that the trust is working with its' commissioners regarding a specified paediatric emergency pathway in the county.

The trust said it was concerned that there was no consultant paediatrician cover for 16-17 year olds admitted as inpatients and is in discussion with Commissioners. Currently the commissioning body has a policy of patient choice between admission to Poole or the Royal Bournemouth Hospital, for this group of young people.

Multi-disciplinary working

At inspection in August 2014 we saw excellent and consistent examples of multi-disciplinary working within A&E and AMU. There were specific care and treatment pathways, which ensured that patients received the correct treatment and care. We spoke with allied health professionals, including an occupational therapist who told us she was arranging a complex discharge for a patient in the observation bay in the A&E department.

Senior staff acknowledged that the mental health pathway was not effective as it was not a 24-hour service from the local mental health NHS trusts. Patients who required a psychiatric referral sometimes had to wait considerable time for the assessment team member to arrive in the department. Since the inspection in October 2013 there had been a three month pilot of funding to the local mental health trust. This had resulted in some additional out of hours crisis input by specialist staff. However, although the pilot is continuing, there is no longer any money in place to support this, and this is a matter of some concern. There is currently a scoping project in place to look at the potential for a seven day service.

Treatment pathways

Patients' initial emergency treatment was prompt and efficient. Patients travelled throughout the department in a planned manner with individual expertise in place where possible.

Nurses, medical and therapy staff showed a comprehensive understanding of treating people with dementia with care and compassion, even within a busy and fast-moving environment.

At inspection in October 2013 we found patients with a stroke were held up in either A&E or the AMU, before being admitted to the stroke unit. Therefore they did not get the required tests, specialist care or treatment for their condition in a timely manner. At follow up inspection we found patients with a suspected stroke were swiftly assessed before being admitted to the stroke unit. The Clinical Director for Medicine told us he was "happy with the elderly care and acute admissions pathways" and cited improvements over the last nine months. Since the last inspection, nurses were now able to book scans in the event of a stroke being suspected. This has considerably cut down stroke pathway times within the department, and led to a more efficient service to patients.

Patients presenting to the department with mental health issues sometimes had considerable delay to their efficient assessment by a specialist practitioner. During the period Monday to Friday, nine until five, the delays were less substantial. However, in the evenings, overnight and at weekends, they could be waiting in the department for many hours before being seen by a member of this team. Whilst there was some out of hours "Crisis" input, this was no longer funded after an initial pilot. At present, there is a scoping project in place for a seven day service. The Trust Board are fully aware of this situation and seek to resolve it with their commissioners in the near future.

Patient records

At follow up inspection in August 2014 we found improvements had been made since October 2013. Patient records were generally well-completed, with a high compliance percentage of completed assessments.

We looked at patient records and treatment pathway plans on AMU, majors and observation units. The initial emergency admission proforma was clear and well documented by both doctors and nurses. Once admitted to AMU, a 14-day treatment plan was instigated. This included risk assessments for nutrition, skin integrity, venflon sites and falls. Most but not all sections had been completed on the plans we looked at. One person had not had a nutrition score assessment done in the thirty six hour period since her admission. However, this was a single episode due to an agency nurse not correctly maintaining their documentation for the shift they worked. The Matron for AMU was immediately informed of this when it was known, and she had taken appropriate action to deal with this.

There was a nil by mouth (NBM) policy in place; this care directive was written on a white board behind each patient's bed. This was also documented on the handover sheet.

Accident and emergency

We saw that fluid and intravenous fluid records were recorded and were up to date. Two-hourly check lists were completed for all patients in a tick box format. These lacked a person-centred approach and did not reflect whether the delivery of treatment and care had been effective for individual patients. We discussed this with the AMU Matron who stated that the documentation was still quite new, and acknowledged this was a weakness of it that she hoped to address with her staff. New documentation had been put in place after the last inspection and was still in the "embedding" stage.

Are accident and emergency services caring?

Accident and emergency services were caring. We saw many episodes of good care during the two days and one evening we visited in August 2014. This care was delivered by nursing, therapy, medical, reception and ambulance staff.

We heard or observed three outstanding examples of care, which we fed back to the Deputy Director of Nursing, the A&E consultant and the A&E Matron. These included medical staff attitude to an elderly patient and their relatives, a health care assistant's advocacy for a patient living with dementia, and the psychological care of a distressed patient with a mental health disorder; this was delivered by many members of the extended A&E multi-disciplinary team.

Staff approached patients in a calm and kind manner and took the time to talk to them and explain what they were doing and why.

Consent

We saw that staff always asked patients for their consent before taking blood, undertaking any personal care or procedure, or moving them within the department. This meant that staff involved and consulted with the patient before undertaking tests and treatment.

Attitude of staff

During the previous inspection, we found the complaints register had identified that the attitude of staff had been a source of concern in the department. At follow up inspection in August 2014 we found these incidents had been investigated and appropriate action taken as necessary. The reception staff had also received training in customer care.

We spoke with seven patients and their families. People told us the staff had treated them with kindness and sensitivity. Most of them said they had been regularly updated with on-going treatment and care plans. Two people told us that the reception staff on duty were pleasant and helpful.

Throughout the follow up inspection, we saw that staff treated people who were confused or disorientated in a respectful and kind way.

We heard a departmental doctor discuss the care and treatment plan for an elderly patient in the observation bay. They ensured the patient and their relatives had a clear understanding of what tests had been taken, the meaning of the results, what could be expected to happen overnight and the next day, and further follow up information. Understanding was checked at all times, and the opportunity given for questions to be raised. When the doctor left the cubicle, the relatives and patient said they were "reassured by such excellent care and great communication".

We observed a healthcare assistant demonstrating considerable advocacy skill whilst caring for a patient living with dementia. They ensured that the patient was only moved appropriately within the department for their comfort and nursing need, and not just for departmental efficiency. The advocacy of the patient by this member of staff was outstanding and clearly demonstrated the value of the dementia training the department offers its' staff.

We noted several nursing and therapy staff care for a patient with a mental health disorder. The patient was frightened and distressed, and despite the overall busy-ness of the department, we saw that staff continually sought to reassure this person. Staff who were not directly caring for this person made the effort to take time to ensure the person's comfort and need for reassurance.

Assessing mental capacity

We saw documentation that had reference to patients' capacity on admission.Training sessions on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) had been provided for staff. These were both included in the induction programme for new staff. There

Accident and emergency

were also flow charts and files available in ward areas to help staff refresh their understanding and for reference. There were two link nurses for mental health for the department.

Dignity and privacy

In October 2013 we observed mixed sex patients in one observation bay in A&E and in bays in AMU. This had not been documented on the risk register.

At the follow up inspection in August 2014, we looked at how staff promoted and protected patients' dignity and privacy. We saw that observation bays in A&E were single gender only, and this was strictly adhered to. One patient we spoke with said, "It is nice to know it is just ladies in here; I would not feel comfortable sitting in a hospital gown if there were men here". Another person said "I like it being men in this bay; I can feel sick and not be embarrassed".

We noted in the majors bay that windows facing outside did not have any privacy film or frosting. Although patients were always screened prior to examination, there was a possibility that they could be viewed from outside. There were roller blinds in place, but these had not been used. When we asked the staff about these, they told us they were new, and the staff were being reminded to use them.

AMU had single sex bays. One bay of AMU was specifically for the ambulatory care unit and on occasions was mixed gender. Any mixed-gender breaches of this bay was reported in a specific log and escalated to the General Manager during the day and the clinical site team out of hours. There were 13 mixed gender breaches in July, and 16 in August at the time of our inspection.

Are accident and emergency services responsive to people's needs?

(for example, to feedback?)

At inspection in August 2014 we found accident and emergency services were mainly responsive to individual need. There were some challenges in timeliness of response for patients requiring, for example, specialist mental health interventions. However, this was due to the limited availability of local community mental health provision. The care pathway for children aged 16-17 years who required inpatient admission following attendance at the department needed to be more robust. Local commissioning arrangements meant that children of this age were also cared for at Poole Hospital, where many families chose to attend because of the on-site children's ward.

Whilst at team level the staff were responsive to people's needs, overall responsiveness was limited to the actions that the Board agree to, including the terms of commissioned services.

Safety issues

Staff told us that they submitted risk alerts when the department and AMU were full to capacity.

The incident records showed that senior staff had put an action plan and safety risk assessment in place for the patient reception area in April 2014. This documented actions taken, including fitting a permanent safety glass screen to the reception area and relocation of a panic button. The staff saw this as an improvement. Staff told us this screen had diminished threatening behaviour towards the reception staff, although several patients had written to say they thought this was unnecessary.

Complaints

There was an effective process to monitor and review complaints and suggestions for improving the service.

The noticeboard in the waiting room had visual information about complaints; how to make them, current and past themes and graphs indicating different types of complaints. We spoke with the Matron about current complaints strategy. She told us that complaints management was dealt with by individual and team feedback and by training where necessary. Departmental strategy involved contacting the complainant to try to resolve the issue quickly and where able, to the person's satisfaction. The current number for complaints in the department was a significant improvement on last year and our findings at inspection in October 2013.

Major incidents

The department was prepared to handle unforeseen major incidents. It had a Major Incident Response Plan, which had been reviewed and updated regularly. It rehearsed its response with an annual table top exercise and regular live major incident exercises.

Radiology

In October 2013 we found there were issues around radiology in relation to delayed diagnosis of patients

Accident and emergency

admitted with a suspected stroke. Patients needed a computerised tomography (CT) scan within one hour of admission to the hospital. We were told that this did not always happen, because the radiology department did not have an agreement to accept CT request forms from non-medical staff.

Since that inspection the trust had introduced a new pathway for faster access to the Stroke Unit and this included access to CT scans. Data showed the trust to be below the national for CT scans completed in one hour and in 12 hours and for thrombolysis treatment to be started within one. However the trust was now meeting the national averages for admission and thrombolysis treatment within four hours.

Are accident and emergency services well-led?

At follow inspection in August 2014, we found A&E was well led, and we found the department had clear leadership for both nursing and medical staff. However, there was evidence that some on-going issues, for example staff and patient security and effective treatment pathways for children and people with mental health disorders had not yet been fully resolved at Board level.

Despite this, staff assured us that the Board were aware of these issues and were working with local stakeholders. Staff were hopeful of early resolution to provide even better care to their patients.

Team working

Staff said they had excellent departmental leadership, which motivated the team. Nursing staff told us how much they valued their Matron, how she worked for them and with them, and how she continuously raised standards of quality within the department.

Staff told us there was an open culture where they could raise concerns and these would be acted on. Clinical and nursing staff were very dedicated and compassionate. Staff said they were proud to work at the hospital and be involved in improvements. We observed a strong team spirit and staff told us they worked well as a team. They felt empowered by the changes to the senior management structure in the past 18 months and felt that the department had improved.

Trust Board

We looked at clinical governance arrangements to assess whether there was staff engagement at board level and to determine whether assurance processes were in place to monitor patient safety. There were appropriate clinical governance arrangements to report and manage risk, and clear processes for escalating risks to the trust Board.

Although this had not yet ensured that issues of safety/ security were always fully resolved to staff's satisfaction, the staff told us they felt assured that the senior staff who had recently undertaken "walk-rounds" now had a greater understanding of how the department ran. The staff told us the department ran more efficiently and effectively since the last inspection in October 2013.

Training

The department was led effectively to support staff with adequate training. Staff said they had received mandatory training, and there were opportunities for continuing professional development for nurses to enhance their skills such as developing advanced emergency care nurse practitioner roles.

There was evidence of regular teaching sessions for junior doctors. This included a protected two-hour weekly teaching session. Every doctor was supported by a clinical supervisor. Doctors confirmed to us they felt well supported and were able to approach their seniors if they had any concerns.

Performance monitoring

There were audits of performance, such as the time taken to receive results of scans and X-rays, which had improved significantly and provided an effective service to patients.

Medical care (including older people's care)

Information about the service

Acute medical care services at the Royal Bournemouth Hospital are provided over a number of wards and departments. They provide care and treatment for gastroenterology, thoracic care, coronary care, stroke care, and medicine for the elderly.

Following the inspection of the service in October 2013 the trust had restructured the medical directorate and created a separate Elderly Care directorate. The wards where concerns were identified at the previous inspection were now within the specialist elderly care directorate.

During the follow up inspection August 2014 we visited wards 3, 22, 25 and 26 elderly care wards, and wards 27 and 28 on the Stroke Unit. We visited these wards because these were the speciality areas where concerns were identified within the medical services at the inspection in October 2013.

We also spoke with 18 patients, two relatives and 16 members of staff. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also used information from comment cards received during the inspection .

Summary of findings

At inspection in October 2013 we found that the quality of patient care varied between the medical wards and units. The patient experience was worse on Ward 3 and Ward 26 than the rest, although there were concerns throughout due to staffing levels. Some patients told us that they felt their care had not been delivered in a safe and dignified way. Some had concerns about the numbers of nurses on the wards and felt that their care had been compromised by a lack of staff. We heard about a patient who had had fluids and food restricted in error, and some had not been treated with dignity and respect. We found examples of incidents that staff had not reported through the reporting system. Staff told us they were fearful of the high bed occupancy and the pressure this placed on them.

At follow up inspection in August 2014 we found improvements had been made. Patients were happy with the care and treatment they received. They felt the care was safe, there were sufficient staff and they were treated with respect and dignity. Staffing levels had been reviewed, and the staffing levels had been increased in line with the dependency and acuity of patients on the wards. New staff had been recruited and where there were still vacancies, block booking of agency staff had ensured the staffing numbers were generally maintained.

Shortfalls in recording of care and undertaking of equipment check were being addressed. Training and support for staff was provided and records were being audited daily. Patients with dementia received good care with staff routinely receiving training about caring for patients with dementia.

Data showed the trust to be below the national averages in five out of ten areas of stroke care. For patients admitted into hospital with a stroke, the availability of specialist consultants and nurses meant it could not be assured they would be seen by a stroke consultant and stroke nurse within 24 hours. This was not in line with national benchmarking and had the potential to compromise their care and potential recovery. The data also showed the trust to be below the national for CT scans completed in one hour and in

Medical care (including older people's care)

12 hours and for thrombolysis treatment to be started within one. However the Trust was now meeting the nation averages for admission and thrombolysis treatment within four hours.

Discharges from hospital were well planned, and discharge planning now started on admission to the hospital Action was being taken to reduce the number of delayed discharges that occurred because of delays in home care arrangements being set up.

Staff were positive about the new management structure for the Directorate. They felt supported by both their managers and their senior managers.

Are medical care services safe?

At inspection in October 2013 we found that patients were often not safe.

At follow up inspection in August 2014 we found significant improvements had been made to the safety of the service.

Feedback from patients

During the inspection in October 2013 relatives discussed care that indicated patients did not always receive care that protected their safety. At that time, this included a relative being asked to help a nurse in lifting their relative up the bed and a second patient being left Nil by Mouth, missing breakfast and lunch, when there was no clinical reason for them being Nil by Mouth.

At the follow up inspection we spoke to 18 patients, two relatives and received 75 comment cards. None of the information we received indicated patients felt the care and treatment they were being given was not safe. Comments from patients included, "I've been treated well" and "Absolutely terrific, I can't fault it in anyway." A relative told us they had "Absolutely no complaints, just the opposite."

Staffing levels

At the inspection in October 2013 it was identified that patient safety was being compromised because of a shortage of nursing staff. The impact of this was greater on the elderly care wards. Following this inspection Trust told the Commission they were implementing a recruitment plan to establish a substantive workforce across all inpatient areas and to create capacity to manage short-term sickness and the expected level of staff turnover.

At the follow up inspection in August 2014, the number of staff planned for each shift and the actual numbers on duty each shift were displayed on electronic boards at the entrance of all wards. The planned staffing numbers (staffing template) was set and reviewed six monthly by the Director of Nursing, who used a variety of recognised tools and the professional judgement of staff working in the clinical areas. Following the previous inspection some of the elderly care wards had been re configured. As a result the staffing template for those wards had been amended to increase the staffing numbers in line with the dependency and acuity of patients on those wards.

Medical care (including older people's care)

Records showed that nursing vacancies were the highest in the elderly care directorate. To address this the trust had employed nurses from overseas and had developed links with Bournemouth University with a view to recruiting newly qualified nurses. We were informed that 33 newly qualified nurses were commencing employment in October 2014 across the trust. Some of these would be working in the Elderly Care Directorate, however we were not provided with the detailed numbers for the directorate. To mitigate the staff shortages whilst waiting for new members of staff to commence employment, the trust had block booked agency nurses and health care assistants to ensure continuity of care for patients.

The nurses employed from overseas had commenced employment at various dates since April 2014. This had allowed for a customised induction programme for each individual based on their needs, previous experience and language skills to ensure patients received care that was safe and effective. This customised induction programme was confirmed in the conversations we had with overseas staff.

There were clear protocols to follow if the staffing numbers did not meet the staffing template. This included the use of a safety briefing check each day as to whether the staffing numbers met the staffing template numbers and the escalation of the need for members of staff to the elderly care matrons who if able would reallocate staff from other elderly care wards or request agency nurses.

Patients told us there were sufficient numbers of staff on duty most of the time. Comments included, "There are enough staff", "This ward has a lot of staff" and "Staff don't appear overstretched, they have time to have a chat." However some patients expressed they felt staff levels at night were not always sufficient. Comments we received included, "There are loads on during the day, but not many at night" and "There's not enough staff on the night shift, if there's an emergency you get forgotten. The trust was reviewing feedback about aspects of patient experience of 'hospital at night'.

Patient records

The inspection in October 2013 identified a deficiency in the recording of patients' wound care.

During the follow up inspection in August 2014 we looked at records for 12 patients.

Monitoring of wounds was completed. There was a specific care plan for wounds that included an assessment of any pressure ulcers, a body map so the position of any wound could be identified and a description of the dressing and frequency of dressing. We saw evidence in patient records of the involvement of tissue viability nurses.

We identified a lack of accurate recording of fluid intake for patients on the wards. We observed patients were offered and supported to have drinks, however this was not consistently recorded on their fluid intake charts. For one patient on Ward 3 their fluid record chart indicated that may have had only 660mls in a three day period. We raised this as a concern with the senior nurses on the wards. When we completed the inspection on 18 August 2014 we saw that action had been taken to improve the documentation of fluid intake. This included a matron providing support and training to ward staff with regard to the importance of recording fluid intake and reviewing whether all patients needed to have their fluid intake monitored.

We spoke with junior medical staff. They told us that if they requested, nursing staff kept a clear and accurate record of patient's intake and output. They did not have any concerns that patients were not receiving adequate fluid intake. They confirmed that as well as nursing records, they would use their own assessments to judge if a patient was becoming dehydrated.

Medicines management

At the inspection in October 2013 there were no concerns identified with the management of medicines for medical care. We found that policies were in place to administer medicines safely and that staff were aware of the policies. On the stroke ward, we were told that pharmacists visited the wards daily and checked that medicines were being stored and administered safely. We observed part of the stroke ward medication round. The nurse was careful when checking the identity of the patient, and we also saw that the nurse waited to ensure that the patient had taken their medication before they signed the medication record.

Equipment

At the inspection in October 2013 it was identified that in most ward areas, storage space for essential equipment was limited. In one ward area it was reported that staff often found the hoist was not charged and ready for use when it was needed because there were not enough

electric sockets near to where equipment was being stored. If hoists were not charged, it could mean that patients would not be moved safely and in a timely manner when they needed assistance.

During the follow up inspection in August 2014, we saw that for some wards there was still a problem with the storage of equipment. This specifically affected ward 22 where hoists were stored at the bottom of one of the bay areas. However, provision had been made to ensure all hoists were charged and accessible for use when needed. Conversations with staff and patients confirmed that hoists were always accessible for use.

At follow up inspection in August 2014 we also noted that processes for ensuring resuscitation equipment was in safe and working order were not consistently followed. On ward 3 there were records of checks of resuscitation equipment, but it was not consistently recorded that the daily checks were completed. The same was found on ward 25. On both wards this was noted by the ward sister and action taken immediately to ensure all checks were recorded.

Safety monitoring

We saw the systems for collecting monthly data in the wards and units, which is measured using a standard NHS Safety Thermometer data collecting tool. This required staff to collect information on hospital acquired pressure ulcers, in-patient falls, hospital acquired venous thromboembolism, and urinary catheter associated infections. Most wards used a system of safety crosses to do this. Wards displayed this information, which enabled staff and visitors to see how the ward was performing against these safety criteria.

Are medical care services effective?
(for example, treatment is effective)

In October 2013 we found that services were mostly not effective. At follow up inspection August 2014 we found improvements had been made. .

Patients with dementia

The inspection in October 2013 identified that staff had to express an interest in order to attend dementia awareness training, and so this training was not attended by all staff. During the follow up inspection in August 2014 the elderly care matrons told us that the trust had implemented three tier dementia training, with all staff having to complete the first tier as part of their mandatory training. Training charts on the ward areas evidenced that staff were receiving this training.

Senior nurses and clinical leaders on the elderly care directorate had identified that when a patient who had dementia and exhibited challenging behaviour they needed one to one support, this was usually done by an agency or bank health care assistant. This meant these patients were being supported by staff who generally did not have the specialist skills to support them. To resolve this issue the directorate were planning to train a cohort of health care assistants in the skills to provide meaningful care and support to dementia patients. They would be deployed to provide this support when needed.

Patients with dementia had a copy of the 'This is Me' booklet. This is a booklet published by the Alzheimer's Society which people with dementia can use to tell staff about their needs, preferences, likes, dislikes and interests. However, these were not consistently completed. This meant staff working at the hospital might not be fully informed about the most effective way to support the patient.

One of the wards (Ward 26) had been completely refurbished so that the environment met the needs of people with dementia.

Assessment

At the inspection in October 2013 some patients and relatives felt that they had not received good treatment as patients were being placed in wards that did not specialise in their conditions, and therefore staff were not trained to meet their specific needs. An example was given that for one patient they remained nil by mouth for 4 days waiting for a swallowing assessment, because staff on the wards did not have the skills to perform the assessment.

At the follow up inspection in August 2014, we saw that patient's care records provided clear prompts for nursing staff to assess the wellbeing and needs of patients at intervals that were appropriate to the individual's clinical condition. We saw evidence in patient's records of referrals to speech and language therapists (SALT) for assessment of safety with swallowing. We saw evidence that advice from SALT was incorporated into the care planning and was followed by care staff.

Medical care (including older people's care)

Each day the elderly care matron visited patients that were located on wards other than elderly care wards. This meant the patients' assessments, care and treatment were being reviewed by an elderly care specialist to ensure they were receiving the correct care and treatment.

Because of bed shortages some patients were being treated by the stroke therapy team sometimes had to be cared on wards that were not part of the stroke unit. In this situation the patient would continue to be assessed and receive their therapy from the specialist stroke therapy team. This meant they received the appropriate therapy to enhance their recovery from stroke.

Stroke care

At the inspection in October 2013 and in August 2014 we found that once patients were admitted to the stroke unit they were offered a very good programme of treatment and rehabilitation.

The unit also facilitated patients to have early supported discharge, where appropriate. This meant that people were able to go home and be supported with their rehabilitation within the community setting.

In October 2013, the ward sister told us they had attempted to trial an outreach team approach to ensure that stroke patients on other wards were seen by nurses and members of the multidisciplinary team (MDT) with specific stroke training. However, the trial had not been a success as the ward had not been able to release the nurse to the wards due to staffing pressures on the stroke unit. At the follow up inspection in August 2014, we were told that this situation was unchanged. Staff had received training and had the skills to provide an outreach stroke service to patients on other wards of the hospital. However, they were still not able to provide this service because there was insufficient staff to be released from the ward. Staff told us that if they could provide this service; they would be able to visit the general wards, identify patients who had suffered a stroke and provide immediate care and treatment to them with the aim of enhancing their recovery.

At the last inspection it had been identified that there was effective MDT working during week days, but the lack of seven day therapy services meant patients did not always receive therapy at the weekends. Since the last inspection seven day working for therapists had been introduced, including speech and language therapy (SALT). This meant that stroke patients received therapy seven days a week.

Medical care for stroke patients out of hours was fragmented and inconsistent. Stroke patients who were admitted to the hospital out of hours (6pm – 8am and at the weekend) were seen by the on call medical team, who were not part of the stroke team and who may or may not have had experience in stroke medicine. There was the risk that a patient with a stroke might be admitted to hospital on a Friday evening, but not be seen by a stroke consultant until Monday morning.

The stroke unit provided data to the Sentinel Stroke National Audit Programme (SSNAP). This programme aims to improve the quality of stroke care by auditing stroke services against evidence-based standards and national and local benchmarks. The latest data form the audit (January - March 2014) showed that the Stroke Unit had not been meeting the benchmark standards for five of the ten areas audited. The data confirmed the information staff had given regarding out of hours access to specialist staff. The unit was not meeting the targets for patients with stroke to be seen by a stroke consultant and a stroke nurse within 24 hours of admission to hospital. The data also showed that for the period January to March 2014 the Trust had not been meeting the national target for patients with a stroke receiving a CT scan within one hour and 12 hours of the event. However, during the inspection, we were told new arrangements in the A & E department to speed up the process for patients with a suspected stroke receiving a CT scan. The data also indicated that the trust was still functioning at below the national target for patients receiving thrombolysis within one hour following a stroke (Thrombolysis is a specialist treatment that is used for patients whose stroke is caused by a blood clot). There was an improvement in the time for patients to be admitted to the stroke unit and being commenced on thrombolysis treatment, with the Trust meeting the national targets.

Are medical care services caring?

At the last inspection in October 2013 we found that medical services were not always caring. At follow up in August 2014 we found that medical services (including older peoples care) were caring.

Dignity

At the last inspection in October 2013 we found that some patients on Ward 3 had experienced poor episodes of care which had resulted in their dignity not being protected.

Medical care (including older people's care)

During the follow up inspection in August 2014, we did not find any concerns that people's privacy and dignity had not been respected. Patients told us their privacy and dignity was respected. Comments included "They're friendly and call me by first name." A second patient confirmed that staff called them by their first name, but only after they had asked permission.

We observed staff/patient interactions on the wards, including a 30 minute SOFI (structured observational framework) observation on ward 26. Staff spoke with patients in a respectful and inclusive manner, involving them in choices for example about what to eat and drink. Staff enabled patients to eat their meals independently by providing them with spoons so they were able to eat their meals on their own.

Privacy and dignity of patients was promoted by the use of curtains around their beds, or closed doors in side rooms. We did not observe any incidents when patient's privacy was not being respected.

Nutrition

At the inspection in October 2013 it was identified that for one patient their nutritional wellbeing was not promoted, drinks and food were left out of their reach which had resulted in the person losing a significant amount of weight. At the follow up inspection in August 2014, we observed that when meals were delivered they were placed in reach of patients and that patients had drinks placed in accessible areas. We observed staff supporting patients with eating and drinking. .

Patient feedback

At the inspection in October 2013 patients and relatives were in general happy about the care they received. .At the follow up inspection in August 2014 we spoke with18 patients. All made positive comments about the caring nature of staff. Comments included, "The people here are fabulous" and "They're very friendly. They can't do enough for you."

Choice and involvement

The inspection in October 2013 found that patients had been given choices around their care and that staff had spent time. Observations, discussion with patients and staff at the follow up inspection indicated that patients were still given choices and were involved in making decisions about their care and treatment.

Mixed-sex areas

At the previous inspection in October 2013, it was identified that that the Hyper Acute suite on the stroke ward was mixed-sex. This is common and accepted practice in the acute management of stroke patients.

During the inspection in August 2014 we noted that this area remained a mixed sex area. However, we noted that some patients who were not being intensively monitored remained in the mixed sex area whilst a bed on the rest of the stroke unit was being sourced. This meant that patients were potentially being nursed in a mixed sex area when there was no clinical requirement for to be there. The current policy for mixed sex areas was that patients had to be moved to a single sex area 24 hours after they no clinically required the intensive monitoring in a mixed sex area. The Director of Nursing and the Chief Operating Officer told us this policy was currently under review by Dorset Clinical Commissioning Group so that all hospitals in Dorset would have the same time scales for patients to be moved out of mixed sex areas when they were no longer clinically required to be cared and treated there.

Are medical care services responsive to people's needs?

(for example, to feedback?)

In October 2013 we found that medical services were not always responsive to people's needs. At follow up inspection in August 2014 we found improvements and medical services were now more responsive to people's needs.

Radiology

At the previous inspection in October 2013 we found that CT radiographers were not on site 24 hours a day, which meant delays in CT scans could significantly affect people's chances of recovery. It was also identified that for some procedures junior doctors without required guidance had to consent patients for procedures. During the follow up inspection in August 2014 we asked staff about access to CT scans and the process for gaining consent form patients for procedures. Their responses did not indicate patients were delayed in having CT scans, nor did they express any concerns about the process for consenting patients for

procedures. They told us if a junior doctor was not confident, they would always refer the consent process to a more senior doctor who understood the procedure and the risks associated with it.

Delayed discharge

At the previous inspection in October 2013 we identified that there were delays in discharging patients who required complex care packages in the community. This was mainly related to patients on the elderly care wards. Since that inspection the trust has reconfigured the elderly care wards and the creation of a short stay assessment ward (Ward 22) for older patients who require up to five days in hospital. This has resulted in discharge panning commencing immediately on admission to hospital. An Older Person Assessment and Liaison (OPAL) team with, specialist medical, nursing, social work and therapy staff, has been established to assist with supporting patient flow through the hospital and discharges.

The trust has introduced an intermediate care team to assist with discharges home where delays in accessing home care delayed discharge. Therapy and care staff provided support and care to the discharged patient in their own home, until home care packages had been set up. This has enabled patients return home and has reduced the number of delayed discharges.

Are medical care services well-led?

At follow up inspection in August 2014 we found there had been improvements since the inspection in October 2013, and strengthening of clinical leadership so they were now well-led.

Learning from incidents

At the inspection in October 2013 it was identified that processes across the trust for learning from incidents to be shared across the trust were not fully effective.

At the follow up inspection in August 2014, staff reported they received feedback about incidents and changes made across the trust and at individual ward level in their directorate in response to incidents. The clinical matron across Ward 25 and 26 on the elderly care directorate took account of learning from incidents when planning how to support and train staff on those wards. Information about good and successful practice was also cascaded to all staff through the trust's intranet site.

The elderly care matrons explained how they were developing the service in response to both incidents and feedback from staff, patients and the public.

Feedback from staff

At the previous inspection in October 2013 we had varied responses from staff about whether services were well-led. Some staff, mainly on the elderly care wards, felt their managers did not care about them or the patients. Following the inspection the trust created a Care of the Elderly Directorate which included posts of elderly care and clinical matrons. There were also changes made with the staffing of some of the ward areas which included the recruitment of some new ward sisters/charge nurses.

All staff we spoke with at the follow up inspection in august 2014 spoke positively about the new structure of the directorate and about the support they had from the ward sisters/charge nurses and matrons. They felt they had good leadership, and they could approach the ward sisters/ charge nurses and matrons for any support they needed.

Surgery

Information about the service

Surgical services at the Royal Bournemouth Hospital are provided as inpatient surgical wards, including a surgical assessment ward. There are day surgery/short stay units and a Treatment Investigation Unit. There is a main theatre suite and a specific theatre for ophthalmic surgery.

The hospital provides a range of surgery. These include orthopaedics, upper gastroenterology, bariatric surgery, colorectal, urology, vascular, endocrine, dermatology and breast surgery.

At follow up inspection we visited the surgical inpatient wards, day surgery and theatres during the day on 13 and 14 August 2014. We also spoke with members of hospital staff. We observed care and safety practices being provided and looked at 10 sets of records relating to people's health and care needs.

Summary of findings

The inspection in October 2013 found the safety of patients could be improved. We saw that staff were very busy and although patient care was safe, staff told us that they often worked with fewer staff than was needed. Staff told us they found this stressful and that sometimes patients had to wait for their care.

At follow up inspection in August 2014 we found the safety of patients had improved. Staff told us that there had been a nurse recruitment drive and there were now more staff on the wards than before. They also told us that response to patients had also improved. We spoke to patients and their relatives who told us that nurses responded to their needs in a timely manner.

The trust had implemented a new system for identifying the number of nurses required on the ward. As a result, the numbers of nursing staff had increased. At the last inspection we found that junior surgical doctors were not well supported overnight and the medical staff handovers of information at the change of shift were not sufficient to ensure safe practice. At follow up inspection, junior surgical doctors told us they were well supported by senior doctors. The trust had taken action on staffing levels for nursing and medical staff. .

We saw that staff worked effectively and collaboratively to provide a multidisciplinary service for patients in their care. When patients needed care from several specialities of the hospital, this was done effectively to ensure the patients were well cared for.

We found staff were caring and the service responded to patients' needs. Patients were complimentary about the care they received and the professionalism and courtesy of staff. They told us that the service met their needs and that they felt well cared for by the nursing and medical staff.

Surgical services now had clear leadership and there were improvements since our last inspection October 2013. The new nursing structure was getting well-embedded and the appointment of matrons provided clinical leadership within the department.

Surgery

Are surgery services safe?

We found the safety of patients had improved since the last inspection in October 2013. We visited seven wards to observe care being provided and look at records for patients.

Records

We saw that on admission, patients' needs had been assessed and care was planned to meet those needs. Patients' files contained nursing and clinical assessments, risk assessments, care plans and mental capacity assessments, where appropriate. These records were kept by the patient's bedside. A further file contained the medical details of a patient's care, any investigations and results and the daily plan of treatment, which included records of that care and treatment. The records were clear and well-maintained and included clear evidence of discussions regarding care and involvement of patients and relatives, when appropriate. Patients told us that they could read their notes kept at the end of their bed if they wanted to. Staff told us that the systems for recording worked for them and that they felt they had sufficient information to meet patients' needs.

We saw completed records of risks of skin damage, falls and infection, and areas of concern had a risk assessment and a plan of care in place. These risks were regularly monitored and updated and an overall audit was undertaken to monitor the level of each patient's needs. We saw that all audited information relating to infection control was fed back to the surgical units through monthly risk meetings to ensure that the service was aware of current information.

Infection control

All areas of surgical care were seen to be clean and mostly free from clutter. Patients told us that the cleaning staff were always visible and that "the wards were always very clean", that staff were "very fussy" and that "the nurses are forever washing their hands". We saw that infection control measures were followed and staff washed their hands and used protective equipment such as masks and aprons when needed. The theatre department had a specific corridor for removing contaminated equipment. However, this waste then had to leave theatre by the main exit door. Theatre staff said this does not pose a problem or infection control risk to patients as it is removed after surgery has finished.

Safety monitoring

The Director of Nursing had implemented monitoring called the 'Safety Thermometer' to promote patient safety. Staff were able to explain how this system worked and show us the data produced. They also told us that through this data there had been changes on the ward. For example, there had been an additional recruitment of nursing staff. Staff told us that they now regularly received feedback on Accident and Incidents (AIR) forms that they filled out. Feedback on actions taken and the sharing of the learning was undertaken by the ward sister. Information was shared with staff either through the staff meetings or on the bulletin board for staff to see. Staff we spoke with told us feedback on the incident forms gave them confidence that improvements had taken place since the last inspection.

Clinical guidelines

To keep patients safe, the department applied the surgical venous thromboembolism pathway, designed to reduce the incidence of thromboembolisms such as deep vein thrombosis (DVT).

At inspection in October 2013 we found practices and procedures within theatres and recovery were safe. Appropriate checks were in place to ensure the safety of patients undergoing surgery. However, we noted that as part of auditing these checks, there was no clear record of the name of the person who made each check. This meant that there would be no accountability for an error in the checking process in theatre. We saw that the record of a completed World Health Organisation (WHO) checklist was not stored with the patient's clinical records, but stored separately in electronic format. We also saw that although the WHO checklist was audited, any results were not fed back to theatre staff to address any gaps or identified issues. This lack of addressing identified shortfalls did not ensure that systems in place were used to ensure practice was safe.

At follow up inspection in August 2014, we found there was now a clear record of the named person who made the checks of patients undergoing surgery. There was a system in place whereby clinicians involved in surgery came together as a team to discuss each patient and there was

now a clear checking in process with a named individual who was responsible to have undertaken the check. We inspected 10 patient clinical records and found that the completed World Health Organisation (WHO) checklist was stored with the patient's electronic clinical records. The clinical records we inspected also showed that all stages of the checklist were completed. The audit of WHO checklist was shared with theatre staff and any improvements to be made had been identified and actions taken.

Staffing

At the inspection in October 2013 we found there were often fewer staff working on the wards than planned. We saw that most surgical wards and departments, including theatres, were reliant on bank and agency staff to maintain a sufficient number of staff. Staff told us that they were pulled back off training to work on the wards because of staffing pressures. They said that because staff were deployed from other wards, or were agency staff, they sometimes lacked the specific skills needed on that ward.

At the follow up inspection in August 2014, staff told us that staff numbers had significantly since the last inspection in October 2013. The trust had restructured the nursing workforce and had introduced matrons to support ward managers. The support enabled ward managers to focus on quality. Each ward we visited had identified the staff numbers required and the exact staffing on the day. If there was a need for additional staff, there were systems to deploy from bank staff. We checked staff diary records on four wards and found wards had the required number of nursing staff. The Trust had also stopped using agency staff, and bank staff who had previous experience working on the ward were recruited to cover vacancies due to sickness. Doctors told us that there had also been significant improvement in nursing and healthcare support staff. They told us that as a result of the last inspection, the trust had taken significant actions to improve staffing numbers including recruitment from abroad. We asked staff whether they were pulled back off training on the wards because of staffing and all staff told us that the rotas were now organised in a manner that allowed staff to attend training programmes.

Training

Training was on-going and staff felt there was sufficient training for both mandatory areas and some specialist training to support their practice. We saw a forward planning prospectus for training on a wall on one ward. At the inspection in October 2013 we found that training in Human Factors had not been undertaken in either theatres or on the wards. Human Factors is the concept of understanding how workplace factors and human characteristics affect behaviour in relation in safety. These could include if staff were anxious or unhappy about anything. At the time of the inspection in August 2014 we found the trust had taken action and ensured all ward managers in substantive roles and matrons had attended, or were planning to attend, the training. We observed a briefing and saw that staff raised any issues they had about the surgery to be performed.

At the inspection in October 2013, we found some staff were unsure who was looking after medical patients who were temporarily on surgical wards and said they often had to go through the notes to find out who was looking after them. There was an inconsistent approach to this practice across all wards, as some nursing staff were not aware of the medical outliers medical team. This meant that staff may not approach the right medical team to care for these patients and care may be missed or inconsistent. At this inspection in August 2014, staff on wards were clear as to who were medical patients on their wards who had come from other parts of the hospital. Staff also ensured these patients were seen by the appropriate medical team Staff told us that urgent and deteriorating patients were flagged and were seen very quickly, often within 10 minutes.

Handovers

In October 2013 we found there was a limited handover of information between medical staff at the beginning of their shifts. This handover was not formalised and was not attended by a senior doctor. At the follow up inspection in August 2014 we found the handover of information had significantly improved. At each handover, there was a senior doctor in attendance. There was now an electronic patient list to advise the junior doctors which patient needed to be seen. Nurses told us that information from medical staff to the nursing staff had improved. If a patient's condition deteriorated, the doctors attended to these in a timely manner. We were shown an audit that demonstrated that urgent calls to doctors were responded to within 30 minutes.

Surgery

Are surgery services effective?
(for example, treatment is effective)

We found services to be effective at inspection in October 2013.

Patient feedback
Patients felt that their treatment had been effective. They told us that they were happy with their care and treatment they and they spoke highly of the professionalism and dedication of the staff to providing care that met their needs.

Patients told us "I have had several ops at this hospital – no problems" and "Excellent care. No delays in the whole process, responsive and all of the staff were very polite."

Patients told us that they had been admitted and undergone surgery without too many delays. Patients and families both told us that they had felt involved at each step of their hospital admission and knew what was happening with their care. Patients said they had been reassured before going to theatre and had received pain relief immediately when needed, and that when they had asked for more information or help, staff had provided it.

Improvement initiatives
We saw that as a result of patient feedback, initiatives had been put in place to improve effectiveness of services for patients. For example, areas had been set aside for patients to have quiet conversation to protect their privacy and dignity. A system of 'Butterfly signs' had been implemented to enable staff to know when not to disturb patients who may have received bad news or needed privacy. Signs had been implemented for the night staff to know when a patient was having difficulty sleeping and so extra quiet measures were needed.

Complex health needs
Effective processes were in place to meet the needs of patients who were vulnerable. We saw that one patient with multiple complex needs was being overseen by one consultant who coordinated all aspects of their care between other consultants. While in hospital, the patient had their own carer from home and communication between all parties had been effective to enable the patient to feel safe. As a result of this effective working, the staff on the ward had developed a greater insight and means to communicate with the patient and staff felt that a more trusting relationship had developed.

Day surgery
The day surgery units demonstrated that they had effective systems in place to meet patients' needs without admission overnight. Recovery areas were well-equipped and the nurse-led units were well supported by medical staff if they needed further assistance. Systems were in place to manage overnight admission if staff were concerned that the patient was not well enough to go home.

Are surgery services caring?

We found surgical services to be caring at inspection in October 2013 and August 2014.

We observed a positive relationship between staff and patients. We spoke with relatives and carers and they all confirmed that they had felt included in any discussions that were appropriate and felt staff had been professional and courteous.

At our unannounced inspection in October 2013 we heard staff on the ward talking to patients in a way that supported them to make decisions about the best way to make them comfortable and what they would like to drink. We overheard staff asking a patient "Is there anything else at all we can do to make you comfy?"

Patient feedback
Patients told us that all levels of staff were caring and considerate to their needs and wishes. Comments included "Nursing staff are excellent, very attentive, regular check-ups, call system works very well" and "the care has been lifesaving.", "No complaints whatsoever, everybody is well looked after, night staff very well too". Patients also told us that the hostess staff who support patients to have meals of their choice and the cleaning staff on the wards were also kind and helpful.

Patients said they felt safe and comfortable and were treated with dignity and respect. They also told us that they felt they had received the support they needed during their visit to hospital.

Surgery

Involving patients

We looked at records that recorded the views of the patient and, in some instances, their relative or representative, and saw that they were part of the nursing care plan for those patients. We also saw that audits of patients' views about their time in hospital were collated and the results made public outside the ward. This showed that the management of the hospital were keen to ensure that patients and relatives were involved in the development of a caring and supportive culture.

Dignity and privacy

Curtains were pulled around patients when care was being provided and a clip used to hold the curtains closed which stated "Care in progress".

We observed staff answering the telephone. They did not give out any details over the telephone and were careful when they discussed patients' care when on the ward. Records of patients' medical health were held in a trolley by the nurses' station, which was closed when left. This showed that staff respected the patient's confidentiality.

Are surgery services responsive to people's needs?

(for example, to feedback?)

We found surgical services to be responsive to patients' needs.

Patient feedback

Patients told us that they felt the staff were responsive to their needs. They told us that sometimes they had to wait for attention because staff were busy, but generally they were happy with the time they waited for staff to attend to them.

Consent and capacity

Patients were clear about what they had agreed and consented to for the surgery they had. They told us that they were offered the opportunity to speak to a doctor if they had any questions.

We spoke to staff and looked at records relating to how patients with limited capacity were supported to be involved and included in decisions about their care. When a patient was confused, decisions about their care were made in their best interest and whenever possible included the views and agreement of the person's relative or representative.

We saw an example of a patient who needed to have their level of capacity assessed to establish whether they could make decisions about their own care. Staff had recorded the actions taken and the people they had contacted, and provided a clear audit trail of how all decisions had been made.

At the previous inspection in October 2013, we saw two 'Do Not Attempt Resuscitation' (DNAR) records in place. It was not clear whether staff had formally communicated with relatives, as this part of the form was incomplete. At the follow up inspection in August 2014 we inspected five DNAR records and found documentation confirming relatives had been formally communicated with.

Encouraging recovery

The hospital uses an "Enhanced Recovery Programme" to promote improved recovery and discharge. We saw measures recorded on corridors such as "walk here for your 40 metre walk" to encourage patients to progress and see their own improvements.

Patients on the Treatment Investigation Unit told us that the unit enabled them to spend less time as an inpatient as they had investigations and treatment on the unit and then returned home. Patients and staff told us they felt this met patients' needs more efficiently.

Asking for feedback

On each ward there was evidence that the views and feedback of patients had been requested, collected and made available for public view. We saw a "How are we doing?" board on several wards, which displayed patients'' responses to questions and included audits of complaints, falls and hand hygiene. Staff received feedback about audits at staff meetings, which included any comments or complaints from patients about negative aspects of care.

The outreach stoma service was being audited manually, it was a nurse led service which patients said they appreciated.

All patients and relatives told us they were aware of the complaints procedure. Although no-one we spoke to had raised a complaint, they all said they were confident enough to do so if needed.

Surgery

Staff feedback

At the follow up inspection in August 2014 the nursing and medical staff feedback overall was positive. They told us that, since the last inspection in October 2013, although there were demands on medical beds, the movement of patients from medical wards to surgical wards had been minimised. There were also greater controls in place including ensuring there was the skilled staff to meet the needs of such patients. There were now better rota systems in place that ensured staff training was not cancelled because of increase in demand of staff to work on the wards to cover shifts.

At the previous inspection in October 2013, staff also told us about the impact of delayed discharges due to multiple factors outside of the hospital, which were beyond their control. They said these factors meant that the patients may not get the treatment and care they needed without delay. At the follow up inspection in August 2014, we found that the discharge processes for patients began as soon as they were admitted to the wards. We were shown examples of these and found that whilst there were examples of short term delays, most patient patients were discharged from the hospital appropriately and in a timely manner.

Are surgery services well-led?

At follow up inspection in August 2014 we found that surgical services had clear leadership and there were improvements since our last inspection October 2013. The new nursing structure was getting well-embedded and the appointment of matrons provided clinical leadership within the department.

Patient feedback

Patients said the overall service was good and the surgical department at ward and theatre level appeared to be well-run.

Staffing

We saw that each ward had a nurse in overall charge each day, who was supported by further trained staff nurses and health care assistants. Nurse practitioners and medical staff were available by calling them by bleep.

Support for staff

Wards and theatres appeared well-organised. There were regular staff meetings to feedback updates and changes on the wards. The governance arrangements enabled senior staff to look at incidents and trends over each aspect of surgical care to identify areas of risk and develop methods to manage them. The Director of Nursing meets with senior nurses of the surgical units every month and information is cascaded through clinical lead staff to the surgical wards and departments. Staff told us they mostly felt communication was good and that they were able to access updates if needed.

Staff showed us how they report any concerns to senior management and told us that the culture at the hospital supported them to raise any issues without any detrimental effect to them.

Initiatives to support improved medical practice included regular morbidity and mortality meetings across specialities. The junior doctors considered this to be the norm and they were expected to present information, which supported them to develop their practice.

Staff concerns

At the previous inspection in October 2013, some junior medical staff said they were concerned about the availability of junior and middle grade medical staff to assist throughout the night time and weekends.

At follow up inspection in August 2014 we inspected the hospital around the time when the change in junior doctors had just taken place and new and inexperienced doctors were working on the wards. Junior doctors we spoke with at this inspection told us they were well supported. They told us they did not feel isolated working at nights and had the necessary support of their senior doctors. One junior doctor told us that on the night they started their shift, they had three calls from their senior doctor to query if they needed any support. Another junior doctor was visited by their senior doctor at night to enquire about any support they required.

At the inspection in October 2013, junior doctors raised concerns that they did not have easy access to a more senior doctor between 11pm and 7am. They felt anxious that they may miss sick people through a lack of their own experience and told us that this made them feel vulnerable. At this inspection, junior doctors told us they were very well supported by their senior doctors throughout the 11pm to 7am shift.

At the inspection in October 2013, junior doctors told us that they were often called to take blood from patients or insert cannulas (medical devices that provide lines for

taking blood and administering medicines and fluids), as many ward staff could not do this. They were unaware that there was an appointed support worker overnight on the wards to do these tasks. At the follow up inspection in August 2014 we found junior doctors were aware of the support available to them for the drawing of blood and the insertion of cannulas. They knew they could call specialist staff to do so and this helped them with their workload.

At the inspection in October 2013, nursing staff expressed concerns about the pressures of not having the appropriate level of staffing to meet people's needs. They said the leadership of the hospital were aware of these concerns but had not supported staff to address the issues. At follow up inspection, we spoke with matrons and ward managers who told us that since the restructuring of the nursing directorate, there had been considerable support put in place to ensure the voice of the nurse was heard. There had been additional staff recruited. There was an additional recruitment of nursing staff from overseas. All escalation beds (to support increased demand) on the surgical wards had been funded for additional staffing. Ward managers told us that if they felt safety was compromised, their requests for additional staff were heard.

Intensive/critical care

Information about the service

The Critical Care Unit accommodated both the Intensive Care Unit (ICU) and High Dependency Unit (HDU). There were 12 beds on the unit, which could be used flexibly to provide care and treatment to critically ill patients or those requiring high dependency nursing care.

We visited the Critical Care Unit on 24 October 2013. We spoke with one of the six patients using the service at the time of our visit. We also spoke with two doctors, a physiotherapist, three staff nurses, two senior nurses and a member of the outreach team.

The Critical Care Unit was not visited at follow up inspection in August 2014.

Summary of findings

Inspection in October 2013 found the service was safe, effective, caring, responsive and well-led. We found that people were protected from the risks of infection, and changes to practice were made following learning from incidents. Care was planned and delivered to meet patient's assessed needs by staff who had appropriate skills and training. Patients were treated with dignity and respect and their privacy was maintained. Staff were aware of their roles and responsibilities and there was a clear leadership structure. However, patients were not always discharged promptly when they no longer needed intensive care.

Intensive/critical care

Are intensive/critical services safe?

The unit was safe and secure.

Security

We saw that access to the unit was restricted and entry was through an intercom, which ensured that only those who were authorised were admitted.

Equipment

Equipment, such as ventilators and medication pumps were standardised, which reduced the risk of error in using these medical devices.

Infection prevention

Patients were protected from the risks of infection. We saw that hand hygiene facilities such as hand washing basins, a surgical hand washing trough and hand sanitizers were available throughout the unit. Staff used disposable aprons and gloves, which were available in a variety of sizes, when supporting patients. The number of patients acquiring an infection was low.

The unit carried out audits of practice related to the prevention of infection. For example, staff hand hygiene practice was audited monthly. We looked at the hand hygiene audit results between May 2013 and August 2013 and found that the audit scores had recently deteriorated and the unit had achieved 60%. This meant that staff were not always performing hand hygiene as often as they should.

Awareness of good infection control practice was promoted using posters and notice boards on the unit, and also reflected in the unit's meeting minutes. We found that the unit and equipment was clean.

Reporting incidents

Staff were aware of how to report incidents, and changes to practice were made as a result of learning from mistakes. We spoke with four staff who were aware of the trust's paper-based incident reporting system. They told us that incident reports were sent to the trust's risk management department and to senior nursing staff for investigation. Staff felt empowered to raise concerns and were confident that they would be listened to. Medical staff told us that there were formal arrangements to discuss mortality and morbidity quarterly.

The unit's senior nurse told us that each incident was investigated and discussed at the unit's monthly meeting for clinical leads. We looked at the most recent minutes from these meetings and a summary of incident reports, which demonstrated that incidents were reported, discussed and changes to practice made where necessary. For example, we found there was a delay to implementing appropriate care for one patient with an infectious condition. This incident did not result in harm to the patient, however, the unit had made changes such as the requirement that only senior nursing or medical staff received laboratory results associated with infections. Staff were aware of this change in practice.

Staffing

The unit's staffing arrangements enabled safe practice. One patient told us, "You could not get better staff." The unit was staffed by six consultants specialising in critical care and it had an appropriate number of nursing staff in relation to the dependency of patients. Staff felt there were sufficient numbers of staff to enable them to deliver care safely. The senior nurse told us that agency or bank staff were not used on the unit and regular staff were offered overtime to cover any absences to ensure consistency.

The unit operated a two-shift system, nights and days, and staff rotated through this shift pattern together, with few staff allocated to permanent nights. The senior nurse told us that this enhanced team working and consistency as handovers were minimised. The senior nurse told us that all requests to backfill posts due to absence had been granted. The trust had a critical care outreach team, which supported the hospital 24 hours a day seven days a week.

Are intensive/critical services effective? (for example, treatment is effective)

The unit was effective.

Patients' needs were assessed and care was planned and delivered to meet their needs. We spoke with medical staff, including a consultant and registrar grade doctor. The consultant told us that they were involved in decisions to admit patients to the unit and that patients accessed the unit when required and without delay.

Intensive/critical care

Patient feedback
Patients' needs were met; for example, one patient told us, "There is always a nurse to feed me and assist me. I am never rushed, they take all the time I need."

Care reviews
Patients' care and treatment was regularly reviewed and recorded. We were told that patients were medically reviewed routinely twice a day. We observed a ward round and saw that treatment decisions were reviewed and plans of care changed as necessary. For example, one patient told us, "They have just started me on some new pain killers." We looked at the care records of three patients and found that on-going assessment and delivery of care was recorded. For example, on-going monitoring of patients fluid intake and output and, where appropriate, level of sedation was assessed. We found that the unit measured a variety of patient observations, including their blood pressure and pulse, to enable early identification of any deterioration in their condition.

Multidisciplinary working
Patients were supported by an effective multi-disciplinary team. A physiotherapist told us that designated physiotherapy staff supported the unit twice a day. One patient told us, "I've not been out of bed for a while. The staff on the ward and the physic are helping me." Medical staff told us that there were close working relationships between the critical care outreach team, the emergency department and the unit. We were told that there was good access to interventional radiology. Six members of staff told us they felt they worked well as a team and that consultant decisions were consistent and that they were "a close knit team who think alike." However, we were told that there were occasional difficulties in identifying which medical consultant was involved in a patient's care and treatment.

Staff handovers
Staff received sufficient information regarding patients' needs to enable them to provide effective care and treatment. We found that the unit's shift pattern allowed for a 15-minute handover at the change of shift. We talked to four nursing staff and one therapist, who said they met at the change of shift and received information about each patient's condition. Following this meeting they had a bedside handover in relation to the patient whose care they were taking over. Therapy staff received a handover from the nurse in charge when they arrived at the unit.

Staff training
Staff received appropriate training to perform their roles effectively. One patient told us, "All I can say is these people here are brilliant. You cannot knock them." The unit had designated three members of staff as part of their education team, which included a lecturer practitioner, who had developed an in-house 'Principles in Critical Care' course, which was accredited by the local university. Staff felt they had received sufficient training to perform their jobs. For example, one member of staff, who had worked on the unit for approximately four months, told us that during their induction, they spent a month on the unit as an extra member of staff, and had been allocated a mentor to support them in developing competency by using a workbook.

A report of the unit's training for nursing staff showed that the majority had received appropriate training in topics such as fire safety, resuscitation and safeguarding. However, we found that 33 of the 59 staff detailed on the report had not completed training in falls awareness. They received regular appraisals and each was allocated a named appraiser. They told us they felt supported by senior staff and could ask them for support and guidance when needed. One member of staff said, "I have found the support amazing."

Quality audit
The unit submitted data to the Intensive Care National Audit and Research Centre (ICNARC), which produces comparative reports providing information on the quality of critical care. The report for the unit showed that the service performed within the expected range for most indicators. This meant that patients received a standard of care and treatment that was consistent with other units of this type.

Are intensive/critical services caring?

The unit was caring.

Patients were treated with dignity and their privacy was maintained.

Patient feedback
One patient told us, "They pull the screens around. Privacy is not a problem." We saw that curtains were closed around patients' beds when they were receiving intimate care and signs indicating "care in progress" were used. However,

Intensive/critical care

33% of patients provided feedback to the trust that they were not given enough privacy when discussing their condition and treatment. Patient feedback also acknowledged that privacy was difficult with only curtains separating bed spaces.

Attitude of staff

Patients were treated with consideration and respect. One patient said, "They are friendly, open and natural." We observed staff interact with patients in a sensitive and considerate manner. For example, one patient asked for information about his condition after a nurse had completed their observations. The nurse provided reassurance and information to the patient in a manner they understood.

Support for relatives

We saw that there was a room for relatives to use on the unit and staff told us that overnight accommodation could be provided to relatives on site.

In the waiting area we saw photographs of the beds and equipment used in the unit, which helped people prepare for their visit. Staff had developed a sign to attach to the privacy curtains to indicate when patients had received upsetting news, which helped staff to respond to patients appropriately and sensitively. This sign was a symbol of a butterfly, and therefore discreet.

Involving patients

Patients and their relatives were involved in decisions about their care and treatment. Staff told us that they kept diaries for patients while they were on the unit and also encouraged visitors to complete them. Staff reported that this was important especially when patients were using ventilators, as it helped them fill in the gaps when they no longer required intensive intervention. No diaries were in use at the time of inspection. Patient feedback to the trust indicated that they were involved as much as they wanted to be in decisions about their care and treatment.

Are intensive/critical services responsive to people's needs?

(for example, to feedback?)

The unit was responsive.

Patient feedback

Patients' needs were responded to promptly. One patient told us, "You can ask them for anything and they will do it." We saw that patients' requests were met by staff. For example, when one patient asked for a television, it was brought to their bedside immediately.

Patients were asked for feedback by posters displayed throughout the unit about how to make comments or complaints. Patient feedback cards were available in the waiting area with a box to deposit completed cards. The unit participated in the 'Friends and family test' and received four responses during September 2013 that patients were either 'likely' or 'extremely likely' to recommend the service.

Urgent care

The resuscitation trolley on the unit included appropriate equipment such as portable oxygen, airways and a defibrillator. Staff told us that this equipment was checked regularly and was the responsibility of the nurse in charge. Records demonstrated that the equipment had been checked daily. We found that equipment and emergency medicines were present and within expiry dates.

Staffing

The unit had procedures to respond to fluctuations in demand and was fully staffed regardless of occupancy levels. During our visit there was a full complement of staff with the unit occupied just over half of its capacity. The consultant told us that if there was an increase in demand then the unit would temporarily go over capacity and would transfer out stable patients with the relevant consent. The senior nurse told us that there were virtually no transfers, however, there were staff specially trained to support patients during transfer.

Discharge

There was a risk that patients who were ready for discharge from the unit were treated in mixed sex accommodation as the unit did not have separate male and female facilities. It is not usual practice in critical care to have separate male and female facilities.

There was also a risk that patients' discharge planning may have been delayed. Staff told us that when a patient's condition had sufficiently improved they were not always discharged from the unit until a bed was available on a

ward as the beds could not be reserved in advance. The outreach team told us that they followed up patients discharged to the ward and ensured good links with critical care.

Are intensive/critical services well-led?

The unit was well-led.

Staffing

The leadership of the unit was visible. Nursing staff wore different uniforms according to their role and patients were able to identify different grades of staff on the unit. One patient told us, "It's excellent. You could not better it anywhere, from the top to the bottom."

Staff were aware of their roles and responsibilities and how to escalate concerns. The unit had a clearly identified leadership structure and a coordinator was available on each shift.

Where appropriate, staff had designated lead roles within the unit, for example, resuscitation and organ donation. They told us they were given additional responsibility when they felt sufficiently comfortable and experienced. One member of staff told us that they were the link nurse for spinal patients. This role involved attending training days and providing advice for staff on the unit about this lead area.

Staff were supported with their wellbeing. They told us that they could access the hospital's occupational health service and could refer themselves. They had the opportunity to support a different patient if they felt they needed to, although they also stated that this rarely happened.

Maternity and family planning

Information about the service

The maternity services at the Royal Bournemouth Hospital provide a midwifery-led unit for women with low risk pregnancies in the Bournemouth, Poole and Dorset area. The service comprises an antenatal clinic, three birthing rooms, four postnatal rooms and a postnatal ward with two beds. There are no family planning services.

The midwives deliver over 400 babies each year.

We inspected maternity services on 24 and 25 October 2013. We spoke with five women who were either attending the antenatal clinic or had recently given birth in the unit. We used information from comment cards and patient focus group meetings. We looked at health records, risk assessments, incident reports, minutes of meetings, rotas and training records, and we spoke to the staff working in the unit.

There are no specialist doctors trained in the care of pregnant women or new born babies on site. This means that if any complications arise in labour or following the birth, women and new born babies are transferred to Poole Hospital NHS Foundation Trust or University Hospital Southampton NHS Foundation Trust, where specialist services are available.

Maternity services were not visited at follow up inspection in August 2014.

Summary of findings

Inspection in October 2013 found that the midwifery unit provided safe and effective care for women with a low risk of developing complications during birth. Feedback from women using the service was positive. They told us staff were exceptionally caring and helpful. The service was well-led. Women said they had been well supported throughout their stay in the unit. Improvements could be made where access to scans is limited.

Women using the midwifery-led maternity service can be assured of a good standard of care during their pregnancy and birth, and be confident that that they will be supported in their chosen method of feeding their babies

Maternity and family planning

Are maternity and family planning services safe?

The midwifery unit was safe.

Accreditation and performance

The unit demonstrated a good track record on safety. We looked at the unit's activity since April 2012 and saw that mother and baby safety was within national expectations.

Maternity services achieved a pass in the NHS Litigation Authority CNST Level 2 clinical risk management assessments. This means that the unit has demonstrated there were appropriate policies and procedures in place to reduce risk and the policies were carried out in practice.

The midwifery unit achieved almost 100% in the two-yearly reaccreditation processes from the World Health and UNICEF Baby Friendly Initiative. This demonstrated that the maternity unit had sustained a high level of care and support for pregnant women and their babies since 2011 when the unit was first accredited.

Vulnerable women

The specialist midwife responsible for safeguarding vulnerable women told us about the Sunshine Team. They worked closely with women who were at particular risk of domestic violence and abuse during their pregnancy. They told us how all women were assessed during the antenatal period for any safeguarding concerns. If a concern was identified, extra care and support was put in place. This included working with the family, health visitors and social services to build rapport and improve outcomes for the whole family. The Sunshine Team worked closely with mental health providers, drug and alcohol services and children's services to safeguard women and families identified as being at risk from abuse. This meant that there were better outcomes for families who were assessed as being at risk.

Medicines management

One woman who had recently given birth told us that she always felt safe in the unit. For example, when any medication was administered, the staff always checked her name band.

Access to the unit

We saw security measures to protect the new born babies, such as security bands and key pad access.

Infection control

Appropriate infection control measures included hand gel and public information notices about the importance of hand hygiene. The sluice area was clean, tidy and clutter free. Women in the unit told us the unit was always clean and tidy. The risks associated with infections were minimised as the maternity unit maintained a clean and hygienic environment.

Staffing

There were sufficient staff to provide safe care. The unit was staffed according to national guidelines and although staff sickness was an issue, the women using the service told us this did not adversely affect the care provided. Staff told us they worked well as a team and bank staff provided adequate cover to support the team. The midwives told us that if a woman on their caseload went into labour they would support her through her labour and birth – even if this meant missing breaks. The women we spoke with on the unit told us that there were always enough staff on duty throughout the day and night. They had no concerns about the staffing levels.

Are maternity and family planning services effective?

(for example, treatment is effective)

The midwifery unit was effective.

Clinical governance and audit

Systems ensured the clinical practice in the midwifery unit was evidence based. The trust's Maternity Clinical Governance and Risk Management Group met every three months to review guidance and current clinical guidelines. It was responsible for approving and reviewing maternity policies and procedures and ensuring these were carried out in practice through both national and local audits. For example, we saw an audit of the maternal transfer by ambulance, which included a review of 30 sets of notes. This found that there was good communication between the hospitals, although documentation could be improved. The report included recommendations to simplify how records are completed and the actions that had taken place. This demonstrated that the midwifery services monitored the quality of care and treatment and took action to improve the service.

Maternity and family planning

The maternity unit participated in three of the four national clinical audits they were eligible for. It also took part in the Antenatal and New-born Screening Education Audit, which assessed education in local screening initiatives. This demonstrated that the maternity unit took part in research which contributed to the development of evidence-based practice.

Reporting incidents

The midwifery team demonstrated a good reporting culture over the previous year, with incidents reported and concerns escalated. The Acting Head of the Midwifery Unit explained how the unit learned from these incidents, which were reviewed and discussed within the Maternity Clinical Governance and Risk Management Group. A recent incident had been investigated and had led to a review of the relevant policies and procedures. We heard that although the outcome would not have been affected, there were lessons for the midwifery team in improving communication and ensuring that out-of-hour s referrals and missed appointments were followed up. This learning was disseminated to the individuals concerned and discussed in general at team meetings.

Staff described the process for reporting incidents and said they received feedback following any investigation. They also told us that they felt well supported through the support and debriefing offered to the team following any incident. This demonstrated that the service had systems in place to learn from incidents and improve the standards of safety.

Access to care

The women we spoke with had accessed the midwifery service through their GP. Most women had received antenatal care from their midwife at their GP practice and had only attended this maternity unit for antenatal classes, scans and tests. Midwives told them that if a problem had occurred they would have been transferred quickly to Poole Hospital. Women told us that the community midwives had been very reassuring about the whole process and had explained all the available options without any pressure to make a particular choice.

Collaborative working

Staff told us how the midwifery service worked closely with the GPs and social services, especially in the care of vulnerable women. They gave us examples of how vulnerable women and their new born babies were safeguarded through collaborative working. The maternity service supported multi-disciplinary working and worked in partnership with other organisations to ensure the needs of the expectant mother and her family were properly managed and met.

Patient facilities

The unit was well signposted and clutter free. The birth room had en-suite shower facilities with a birth pool and birth balls. The lighting had a dimmer switch but staff told us that they preferred to use the overhead examination light, which gave a softer lighting effect and was easy to reposition. There were no bathroom facilities on the postnatal ward and one toilet between four beds. There was no television on the postnatal ward. The general environment felt very clinical and did not present as a homely and relaxed atmosphere in which to give birth.

Training

Staff received appropriate training and development to enable them to deliver safe and effective care. Midwives maintained their own training and development portfolios. Staff told us about recent and planned training, including clinical updates such as training in obstetric emergencies, advanced life support, and the trust's annual mandatory training including manual handling, fire prevention and infection control. They said they found the practical elements and support from the consultant at Poole Hospital very useful. Their induction to the unit prepared them well for their first shift on duty. The women we spoke with told us that they felt the staff were competent and caring.

Midwifery staff were supported in their regular supervision and annual appraisal by several staff supervisors in a ratio of one supervisor to 15 midwives, which was within the accepted range. The supervision process was separate from the management of the unit and enabled the midwives to have honest debriefing and reflection sessions about their professional practice.

Are maternity and family planning services caring?

The midwifery unit was caring.

Maternity and family planning

Continuity of care

Each midwife was linked with a different local GP practice, which aimed to have the same midwife follow the woman throughout her pregnancy and birth, although this wasn't always possible.

The women we spoke with told us they felt fully involved in their obstetric care. Although they did not always see the same midwife throughout their pregnancy, they told us that this hadn't been a problem. The women in the unit told us they had the opportunity to visit the unit before the birth, which they found very helpful. They told us how the staff always "go to extra lengths" to make sure they were coping and treated them with dignity and respect.

All the women told us that they had received sufficient information to enable them to make decisions about their care and treatment. They had spoken with the midwives during their antenatal appointments and discussed the benefits and problems associated with giving birth in the midwifery-led unit. They chose to give birth at the Royal Bournemouth Hospital for a variety of reasons, including its close proximity to their home, the fact it was smaller and offered a more personal service, and its good reputation.

Records

Maternity records included detailed information about the different maternity services offered at both The Royal Bournemouth and Poole Hospitals. Women were asked to sign to confirm they had understood the information, that they had had the opportunity to ask questions and discuss any concerns. They were then asked to indicate their first and second choice for their baby's birth – whether at home, in a midwifery-led unit or in hospital. The records contained all the information required to ensure good communication between healthcare professionals and a woman during her pregnancy and birth.

The records stayed with the woman and followed her through the community antenatal appointments, the birth and for 10 days following the birth.

Information and advice

Women's records included useful information including the expected dates of various outpatient appointments and where they would take place. They also included advice on what to do and who to contact in an emergency. There was a checklist for staff for women with a raised body mass index who may be at risk through obesity. This included various tests and precautions, such as checking that the correct size equipment was available and giving lifestyle advice and information. There were various information leaflets available to pregnant women, including advice on breast feeding, smoking cessation and dietary supplements. Women using the service had easy access to advice and information to inform their maternity and lifestyle choices.

Patient feedback

Women praised the staff, telling us how helpful and caring they were in helping them to have positive birth experiences. One woman told us that it was her first baby and the staff had really helped her with breast feeding. She would not hesitate to return to the unit for any other births. Women told us of the kindness of the staff and one said that the midwife had even washed her hair after the birth. One woman said "I've had to use the buzzer loads and the staff always come quickly." All women told us they could not fault the unit. This demonstrated that compassionate care was provided in the unit.

Are maternity and family planning services responsive to people's needs? (for example, to feedback?)

The midwifery unit at team level was responsive to women's needs, but it was restricted by decisions of the Board.

Consultation and feedback

The design of the local maternity services throughout Bournemouth, Poole and Dorset had been subject to public consultation. The local Clinical Commissioning Group had organised a public event which was attended by over 30 women who fed back their pregnancy and birth experiences. The Acting Head of Midwifery told us that the women gave powerful messages, both positive and negative, and she was ensuring that staff heard these messages to inform their practice.

People gave feedback on the quality of care in different ways, including a 'Family and Friends test'. There were also national maternity surveys and 'comment cards'. The midwives encouraged women to phone the unit at any time if they had concerns. This showed that the midwifery unit was committed to communicating with the women using the service to improve their obstetric experience.

Maternity and family planning

Clinical guidelines and policy

We looked at the Maternal Transfer Guidelines and the Emergency Transfer Policy for New-borns. This policy was drawn up with the input of the Royal Bournemouth Hospital, Poole Maternity Unit and the Ambulance Service. The policy was approved by the Maternal Clinical Governance and Risk Management Group and detailed the actions needed to urgently transfer the women and new born babies requiring urgent medical treatment to a consultant-led service and a Neonatal Intensive Care Unit.

Staff were familiar with the policy and were able to describe the urgent actions needed to transfer unwell women and babies safely. Data showed that the transfer rate of women and babies needing urgent medical treatment was similar to other stand-alone midwifery-led units, and outcomes for women remained within national expectations. The unit had safe and effective systems to manage the care of women and new born babies who developed unexpected complications.

Patient feedback

Women receiving antenatal care in the unit told us that they were happy with the service in general, but found appointment times and dates to be inflexible. They did not have a choice of appointment dates as the unit was so busy. They gave an example of ultrasound scans only being available on Thursdays, which was not always easy to accommodate with other family and work pressures.

The midwifery unit had systems to meet people's religious and cultural needs. Staff explained how they could access interpreters when required for women and families whose first language was not English. But they told us this was sometimes a challenge due to time constraints. They had supported women from different cultures such as East European and Middle Eastern areas. They described how they were respectful of the individual woman's needs and were mindful of their privacy and dignity. This indicated that staff responded appropriately to women's individual needs.

Are maternity and family planning services well-led?

The midwifery unit was well-led overall.

Joint working

The Maternity Clinical Governance and Risk Management Group looked at joint working for midwifery services between the Royal Bournemouth and Christchurch NHS Foundation Trust, Poole Hospital NHS Foundation Trust and University Hospitals Southampton NHS Foundation Trust. We saw that partnership working between the trusts was working well, although there was no formal agreement in place. All the staff and patients we spoke with were aware of the joint community and hospital maternity services offered by the trusts and were able to tell us where and how they would access the services.

There was no service level agreement (SLA) in place to record a common understanding about services, priorities and responsibilities. As there was no finance attached, a SLA could not be put in place for the joint maternity services. Instead, the Royal Bournemouth Hospital had included legal cover within contracts for any midwifery work staff may complete while in Poole Hospital.

Staffing

Senior staff in the trust's midwifery services had clearly-defined leadership roles. Although the post of Head of Midwifery Services was vacant, the Acting Head of Midwifery had been in post for some time and had given stability and leadership to the team during a period of challenge and uncertainty. We were told that she was nominated, and had won, the trust Leadership Award in the 2012 Staff Excellence Awards.

The midwifery staff praised her leadership skills and told us that "She is fabulous, the staff are happy and patients' needs are met." We spoke with other senior staff with designated responsibilities such as the Specialist Midwife for Safeguarding and Vulnerable women and the Antenatal and New-born Screening Coordinator. They were all clear about their role and remit, their areas of responsibility and who they reported to. They felt well-supported and their opinions were listened to. There were regular staff and management meetings to discuss issues arising in the midwifery unit. This demonstrated that the service was well-led.

Performance monitoring

The Maternity Clinical Governance and Risk Management Group were responsible for monitoring safety, quality and delivery of maternity services. The Acting Head of Midwifery told us that collecting data to monitor performance was embedded in the unit's culture as it had been a

requirement for a long time. Meetings were held quarterly and reports from this group were fed into the trust's Board meetings through the Governance Committee and disseminated to staff through staff meetings.

Staff told us that communication from the Board down in the trust was good, but they did not always feel the trust listened to their concerns. They gave an example of their concerns about the proposed reconfiguration of the maternity service, which they told us was planned to take place within the next six months.

On the day of our inspection two midwives were off sick and staff had been moved to ensure safe staffing levels in the unit. The Acting Head of Midwifery confirmed that staff sickness was a problem and described the measures she had taken to monitor individual staff attendance and reduce sickness. This included moving to a different model of care, flexible shifts and defined caseloads to reduce stress. She described the positive team spirit throughout the midwifery service and told us that the midwives worked well together to ensure that the shifts were covered. However, although the staffing numbers reflected national guidelines of 1.2 midwives per birth, there was constant pressure to cover the gaps left by staff sickness. The midwives told us that the majority of staff absence was due to the midwives becoming pregnant. They told us that this was not such a problem as the bank staff were very good and were happy to take on shifts. There were actions in place to monitor and address staff sickness and absence.

Services for children & young people

Information about the service

The Royal Bournemouth Hospital only provide paediatric care and treatment of children who have undergone surgery in the Children's Eye Ward. This comprises a three-bedded ward and bathroom facilities, which are directly opposite theatres and next to the adult ophthalmic ward.

There are no specialist consultants trained in the care of children on site. This means that if a general paediatric emergency arises, children would be transferred to Poole Hospital NHS Foundation Trust, where paediatric services are available.

We inspected the paediatric services at the Royal Bournemouth hospital on 24 and 25 October 2013. At the time of our visit there were no inpatients. We spoke with one patient and their mother in the ophthalmic outpatients. We used information from comment cards and patient focus group meetings. We looked at health records, risk assessments, incident reports, meeting minutes, rotas, policies and procedures, training records and spoke with the staff working in the unit.

Paediatric services were not visited at follow up inspection in August 2014.

Summary of findings

Only children's eye surgery is carried out at the hospital. At inspection in October 2013 we found the Children's Eye Ward provided safe and effctive care for children who had undergone ophthalmic surgery. Feedback from patients and their families was positive. They told us the service was very oriented to the care of young people. For example, colouring books were routinely offered during outpatient appointments.

The service was well-led and responded appropriately to the needs of the children. Children requiring ophthalmic surgery at the hospital can be assured of a good standard of care and their families can be confident that that they will be supported during their child's stay in hospital.

Services for children & young people

Are services for children & young people safe?

The children's service was safe.

Incident reporting

The trust had systems in place for reporting and managing risk and patient safety through the central reporting process. The policies and procedures to support staff in reporting any untoward event were on the trust's staff intranet. The unit also had child-specific policies and procedures readily available to staff at the nurses' station on the ward.

Safety measures

The nurses' station had line of sight observations of all three beds. There were extra security measures in place to ensure children could not leave the ward unattended, such as door handles that were out of reach of young children. The play equipment was safe and suitable for a range of ages. The art and craft materials were kept locked away when not in use. This meant that the Children's Eye Ward was a safe and suitable environment for children to receive care and treatment.

Safeguarding

The trust lead for safeguarding children explained how all staff received training in recognising and responding to child abuse at induction and then on a regular basis as part of the mandatory training package. Senior staff received monthly reports that identified where there were gaps in safeguarding training. Any significant gaps were followed up by the safeguarding lead. The Safeguarding Children's Group met quarterly and worked to ensure all staff, including the paediatric nurses and staff working in Ophthalmology, were confident dealing with child protection issues. This demonstrated that children were protected by the trust with robust arrangements to safeguard vulnerable children.

Risk assessment

There were checklists to ensure that each child received safe and appropriate care from admission through surgery to discharge. The admission process included assessing individual risks and checking that risk assessments had been completed. Infection control risks were considered as part of the risk assessment process. The nursery nurse told us how she ensured that toys were cleaned between clinics. This demonstrated appropriate risk assessments were in place to maintain children's safety.

Staffing

There were adequate numbers of appropriately skilled staff on duty on the Children's Eye Ward. We were told that children were not admitted to the ward unless there were paediatric nurses on duty. This was confirmed by looking at the wards duty rota. An information board displayed photos of the staff, explaining who they were. There was a named children's lead for the service and the ward employed specialist nurses such as paediatric nurses and a nursery nurse. The ophthalmic consultants had specialist interest in treating children's eye conditions.

Are services for children & young people effective?

(for example, treatment is effective)

The children's service was effective.

Clinical guidelines

There were systems to ensure paediatric clinical practice was evidence based. The paediatric service had recently been benchmarked against clinical guidelines and best practice standards. Where the standard was not being met, actions were in place to rectify this. For example, the National Service Framework for Children recommended that a Band 7 nurse was employed in any day care unit. This was not in place for the Children's Eye Ward. The issue was reviewed by the Director of Nursing and added to the trust's risk register for action within the last two months. Clinical and paediatric information was readily available on the Children's Eye Ward and staff took an active interest in researching current best practice and developing local clinical guidance. This demonstrated that the paediatric service monitored the quality of care and treatment and took action to improve the service.

The trust participated in one of the two national paediatric clinical audits they were eligible for. This was for paediatric services in general rather than ophthalmic audits. This demonstrated that the trust took part in research which contributed to the development of evidence based practice.

Services for children & young people

Joint working
The safeguarding children's lead told us how they met regularly with local social services and other health and social care providers at the local Safeguarding Board to discuss incidents and best practice. Any issues were brought back to the trust to pass on to relevant department leads. This meant that vulnerable children were protected by the trust working in partnership with other agencies.

Training
Staff received appropriate training and development to enable them to deliver safe and effective care. We spoke with a manager who explained that the paediatric nurses ensured they kept up to date with best practice in nursing children through close links with Poole Hospital's paediatric training and development programme. Nurses also spent time working on the paediatric wards at the other trust.

A manager told us that the staff received regular supervision and an annual appraisal. There were systems in place to support staff training and development.

Are services for children & young people caring?

The children's service was caring.

We saw 'thank you' cards and hand drawn pictures from the children displayed on the ward. One parent told us they were happy with the service provided and said it was very child-friendly and oriented towards young people.

Information and advice
There was easy access to information, help and advice for children and their families about their hospital visit and community support. Leaflets were readily available in the ward in various age-appropriate formats. There was general information about children's services and community support for example, information about a local support group for visually impaired young people. There was also more explicit information about eye conditions and what to expect on admission to hospital. A translation service was available if required.

The ward made the surgical procedure and stay in hospital less frightening for the child and their family, for example, by encouraging families to visit the unit before admission and allowing plenty of time to orientate the child and their relative to the ward. Relatives were encouraged to stay with the child throughout their stay. The child was able to take their family member and a favourite toy into the anaesthetic room. When the child started to regain consciousness after surgery, the relative was called back to the recovery area to support them. According to the child's age staff used dolls to explain what would happen to the child, with cannulas and tubing attached. They told us this meant that children and their families could be reassured that staff would support them to be fully involved in their child's care and treatment.

The ward was well signposted and presented as a welcoming environment to children and their parents. Curtains and soft furnishings were child-appropriate and with toys, books and play materials readily available. The nurses wore tabards decorated with children's motifs to be friendlier for young children.

Are services for children & young people responsive to people's needs?
(for example, to feedback?)

The children's service was responsive to the needs of children and families.

Safeguarding
The safeguarding children's lead told us that the trust had raised awareness throughout the hospital of the safeguarding service for infants, children and adolescents, as most departments in the hospital dealt with children. For example, emergency care services, radiology, dermatology and orthodontics saw and treated children regularly. A recent audit identified the actions the trust needed to take to ensure children across the trust were care for and treated according to best practice guidelines.

Emergency care
The theatre manager was responsible for the care and treatment of children during surgery. He told us that the children had dedicated lists and were always treated as a priority. Information on paediatric resuscitation and the early warning signs for when a child might be becoming seriously unwell were displayed on a notice board for staff to access quickly. Specialist equipment was available to meet children's needs, including children's resuscitation equipment. This was kept just outside the ward to ensure children could not access the equipment. Training in

intermediate paediatric life support for all theatre staff and paediatric nurses was updated annually. This demonstrated that children were kept safe through staff's awareness and training in paediatric emergencies.

Discharge arrangements

The ward had developed discharge policies and procedures, checklists and risk assessments for discharging patients to ensure their safety. Staff were able to describe the procedures to urgently transfer children who were unwell to Poole Hospital, even though this was an infrequent event. The ward had systems in place to manage the care of children who developed unexpected complications.

Cultural needs

There were systems to meet people's religious and cultural needs. Staff explained how they could access interpreters when required for children and their relatives whose first language was not English. This meant that staff responded appropriately to children's individual needs.

We were told that at times the ward was used to support other departments in the hospital when there was a shortage of inpatients beds. They had not needed to cancel any children's surgery because of adult medical patients being admitted to the ward, but it was a logistical challenge to ensure that the Children's Eye Ward was ready to admit children when needed.

Patient feedback

Children and their families could give feedback about the quality of care in the Children's Eye Ward through 'comment' cards. We saw information about how to make a complaint. The ward also used less formal methods to gauge the children's satisfaction with the care.

Are services for children & young people well-led?

Overall, the children's service is well-led.

Before the inspection the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust informed us that they did not have any inpatient paediatric services. There was a dedicated three-bedded children's ward for ophthalmic day cases. We talked to senior staff with responsibilities for the safety, care and treatment of children in the hospital. Staff in the ophthalmic ward had clearly defined roles and responsibilities. There were systems in place to manage the safeguarding of children throughout the hospital proactively.

Staff communication

Staff on the ward were all able to describe the leadership and reporting responsibilities. They were clear about how to escalate concerns and who was responsible for clinical governance arrangements. They told us that the ophthalmic team and theatre staff worked well together. There was good communication and they felt well supported on an individual and team basis. Weekly meetings enabled any issues or concerns to be discussed, along with the day-to-day management of the unit. Quarterly clinical governance meetings monitored the ophthalmic department's performance and discussed any issues. This demonstrated that the Children's Eye Ward had good systems of communication in place and the unit was well-led.

Safeguarding

The trust confirmed that the Board level executive with lead responsibilities for safeguarding children was the Director of Nursing and Midwifery and that there were named healthcare professionals with safeguarding children responsibilities with a nominated safeguarding children lead. The safeguarding children systems were monitored by the trust's Safeguarding Committee and the Board received an annual safeguarding report which included staff training in safeguarding and children who missed appointments. They told us that safeguarding processes across the trust were audited annually. There were suitable arrangements in place to safeguard children and young people from the risk of abuse.

End of life care

Information about the service

The Royal Bournemouth Hospital has an established specialist palliative care team led by a consultant in palliative medicine. The palliative care team provided services for adults with advanced, progressive, incurable illness. The team comprised three specialist nurses and an end of life care facilitator had been appointed on a 12-month contract, to be reviewed in February 2014.

The specialist nurses and end of life care facilitator worked across all wards and departments to support and advise other clinical staff on the care of patients with complex palliative care or end of life care needs.

There were 1,500 deaths a year at the hospital.

At inspection in October 2013, we visited six wards including three, four, five, nine, 27 and 28. We also visited the Stroke Unit, the hospital mortuary, the hospital chapel and multi-faith room. We reviewed the care records of seven patients at the end of life, observed the care provided by medical and nursing staff on the wards; spoke with two patients receiving end of life care and the relatives of two other patients. We also spoke with members of the hospital's specialist palliative care team, the end of life care facilitator and the hospital chaplain. We received comments from our public listening event and from people who contacted us separately to tell us about their experiences. We reviewed other performance information held about the trust.

The majority of patients receiving end of life care were cared for by nursing staff on the wards with support and advice from the end of life care facilitator, as required. Around 10% of patients had complex palliative care needs and were referred to the specialist palliative care team. However, most patients referred to the palliative care team were not at the end of life stage, but needed assessment and symptom control symptom control prior to discharge to their preferred place of care, which may be home, hospice or nursing home'.

End of Life services were not visited at follow up inspection in August 2014.

Summary of findings

Inspection in October 2013 found end of life care services in the hospital were safe, effective, caring, responsive and well-led. Improving end of life care had been a high priority over the last 12 months and good progress had been made on a number of important new initiatives. This included implementing new personalised care plans for the last days of life.

Our conversations with patients, their relatives and care staff provided evidence of good quality care and treatment. Patients and their relatives told us they were fully involved in care planning decisions and were regularly updated on changes in the patient's condition. All the staff we spoke with were knowledgeable, passionate and committed to providing high quality care for patients at the end of their life and their families.

End of life care

Are end of life care services safe?

Patients received a safe end of life care service. In response to national concerns regarding implementation of the Liverpool Care Pathway, the trust had replaced this with personalised care plans for last days of life. The personalised care plans were introduced to support good end of life care and prompt appropriate decision-making, communication and documentation. This helped to ensure a safe approach to each person's care.

We reviewed the personalised care plans of seven patients who were receiving end of life care on six different wards. All contained appropriate records about their medical and nursing needs, clear escalation plans if the patient's condition deteriorated communications with the patient and their family, and their end of life care wishes.

Three records contained 'Do Not Attempt Cardiopulmonary Resuscitation' (DNAR) forms. All sections of the forms were completed appropriately and they were signed by a senior health professional. They included a summary of the communication with the patient, their relatives and members of the multidisciplinary team, as applicable. Completing the DNAR forms ensured that appropriate decisions were made about the care of these patients.

All end of life care that we observed was safe and appropriate to the needs of the patients concerned. For example, one patient was at risk of choking when swallowing. Although they had not had a stroke, they were transferred to the Stroke Unit because of the expertise of staff in this area.

We spoke with a range of staff on the wards including consultants, doctors in training; charge nurses/ward sisters, qualified nurses and health care assistants. All staff spoke highly of the support and advice provided by the end of life care facilitator and the specialist palliative care team. They told us the end of life care facilitator provided hands-on training on the ward as and when specific training needs were identified. For example, they had provided syringe driver training for nursing staff to ensure safe administration of pain relief medication.

Are end of life care services effective?
(for example, treatment is effective)

End of life care services within the hospital were effective.

Comments from patients, relatives and staff on the wards indicated that patients' needs were being met. This was backed up by evidence from the personalised care plans we reviewed.

National reviews

Following a national independent review of the Liverpool Care Pathway, the Department of Health had asked all acute hospital trusts to undertake an immediate clinical review of patients on end of life care pathways. After undertaking this review, the trust introduced personalised care plans for last days of life during the last four months. This was to support good end of life care and prompt appropriate decision-making, communication and documentation.

Following the National Dementia Audit, the trust developed an action plan to address a number of priority areas for improvement. This included identifying patients with dementia and training in end of life care for staff supporting these patients. We observed good practice on the wards, including early assessment and identification of people with a possible dementia. 'This is me' forms were completed to enable staff to understand the person's individual needs and how to support them while they were in an unfamiliar environment.

Care plans

Care needs relating to pain relief, nutrition and fluid intake were clearly documented in personalised care plans and daily care records showed that care was provided in accordance with these plans. We saw evidence of symptom control and other measures to ensure the patient was as comfortable as possible. All the patients we observed looked comfortable and well cared for.

Training

Ward staff said they had received training in mouth care for patients, moving and handling to keep patients comfortable and dignity of the patient after death.

Team working

One of the medical consultants explained that decisions on end of life care were made by a multi-disciplinary team. This included consultation with the specialist palliative

care nurses, relatives and primary care professionals. One of the main decisions was when to move from active treatment of the patient's condition to palliative care. They said there was regular two-way communication between the wards and the palliative care team.

We spoke with the consultant in palliative medicine, two specialist palliative care nurses and the end of life care facilitator. It was clear they were highly specialised in their field and worked closely together as a dedicated team. There was evidence of good collaborative working with other clinical staff across all hospital wards. Every ward had an end of life care champion who met with the end of life care facilitator every month. End of life care champions cascaded good practice to colleagues on the wards.

End of life care facilitator

The end of life care facilitator visited wards twice a week to review any patients who were near the end of their lives and offer care, support or advice as required. The facilitator also provided 'hands-on' training as required, tailored to the needs and requests from each ward. This helped ensure the services provided to patients were effective.

Clinical staff told us the palliative care team had become increasingly active in the hospital over the last 12 months. The end of life care facilitator was appointed in February 2013 on a 12-month project to help roll out the trust's plans for improving end of life care. This included establishing the new personalised care plans for last days of life and the rapid discharge of patients who wished to return home and had family support to do so.

The end of life care facilitator was originally employed for 25 hours a week on the medical wards, but this had recently been increased to a full-time role also covering surgical wards. Referrals from the wards to the end of life care facilitator were steadily increasing, but this was still a developing service. The end of life care facilitator received between15 to 30 referrals a month. However, on their twice-weekly visits to the wards they found there were around 40 patients a month in the last two days of life. This meant a proportion of patients had not been referred to them or put on personalised end of life care plans in sufficient time. The personalised care plans for the last days of life are specifically designed for end of life care and are used in addition to the regular patient care plans used on the ward. The personalised care plans prompt doctors and nurses to check medication, symptom control and treatment decisions, mental capacity, advance decisions, DNAR forms, communications with the patient and/or their relatives, and to ascertain where the patient wishes to die if not in hospital.

We were told that all wards know how to look after patients who are near the end of their lives and the role of the end of life care facilitator was to provide extra support and advice. The facilitator also checked that a personalised care plan was used. The lack of a personalised care plan doesn't necessarily mean a patient did not receive appropriate end of life care, but it does raise the question why this was not used.

Improvement initiatives

There was a trust-wide End of Life Steering Group to drive change and facilitate education and training to ensure the end of life care pathways were effective. The group was to be re-launched and the trust's deputy medical director would become the new chair of the group.

Are end of life care services caring?

End of life care services in the hospital were caring and compassionate.

National survey results

The National Bereavement Survey 2011 collected people's feedback at primary care trust cluster-level. The Royal Bournemouth Hospital is in the Bournemouth, Poole and Dorset PCT cluster, which performed in the top 20% of all PCT clusters nationwide for the levels of 'respect and dignity' and 'quality of care'.

Patient and family feedback

We reviewed the personalised care plans for last days of life for seven patients in six different wards. The care records showed evidence of good quality care, which included notes of regular discussions with patients and their families. We were able to speak with two patients and the visiting family members of two other patients receiving end of life care. All were full of praise for the staff and the care provided, saying staff "went the extra mile" to ensure patient's needs were met and their family members were kept fully informed.

A relative whose spouse had a dementia and received end of life care at the hospital said "The nursing care was loving and caring. They looked after X and the rest of our family very well. We were always greeted and welcomed and they

were flexible about visiting times. We received regular updates. I have good memories and when they died it was very peaceful." Another person's relative said "Communications with relatives are fabulous."

During our public listening event we heard about people's positive experiences of the hospital's palliative care and end of life care services. We saw a letter outlining one person's experience of the pathology laboratory and oncology unit, which stated "Despite poor accommodation the level of care and nursing was superb. We could quote the names of the consultants, the specialist nurses, the sister in charge and many other nurses (all of whom were as good as we could imagine) but our view is a culture of care exists in the unit which continues even when staff change."

A member of the public who had experienced many of the hospital's services phoned us to say "We have nothing but praise for all of the staff from consultants to cleaners and catering staff. The area has an elderly population, the natural order of things means more people are near the end of their lives and many of them will unfortunately die in hospital."

The ward staff treated patients and their relatives with courtesy and respect, and had great empathy. All the patients we saw appeared comfortable and peaceful. We observed high standards of personalised end of life care and exceptional commitment from the charge nurse/ward sisters we spoke to. Ward staff highly commended the proactive involvement of the hospital's palliative care team and end of life care facilitator. We spoke with a group of six doctors in training, who said there was a "caring culture" throughout the hospital.

Bereavement service and chaplaincy

The chaplaincy department provided the hospital's bereavement service, with administrative support from the general office. We visited the hospital chapel/multi-faith room and spoke with one of the hospital's two chaplains. They operated a 24-hour on call system and aimed to be by a patient's bedside within an hour of a request for support. They described their role as being "to pray for the dead and comfort the living".

There were facilities to meet multi-faith spiritual needs, including an area for people of Muslim faith to wash before offering prayers, and a local Rabbi visited the hospital regularly.

The Chaplain directed people to the general office to collect death certificates and a bereavement pack containing important information and guidance on what to do after a death. This included contact details for external counselling and support services, funeral services, bereavement guides and advice.

The Chaplain worked closely with the office manager and other general office staff to help them understand issues associated with people's grief. They praised the work of the general office. Ward staff told us the Chaplain provided great support and comfort to people experiencing bereavement.

The Chaplain also managed the hospital mortuary and provided training and advice to the mortuary porters. We visited the mortuary and saw it was clean and tidy. There was a viewing room where relatives could pay their last respects. Requests for viewing were made through the general office, who then made arrangements with the Chaplain to collect the relative from the general office and escort them to the mortuary, while preparing them for what to expect.

Are end of life care services responsive to people's needs?

(for example, to feedback?)

End of life care services within the hospital were responsive to people's needs.

Conversations with patients, relatives and ward staff showed clearly that the hospital was good at preparing families and patients for end of life care decisions. The personalised care plan records showed an individualised approach to each patient's care and active inclusion of patients and their relatives. Ward staff and members of the palliative care team said the trust had made end of life care a priority over the last 12 months. Staff said the end of life care facilitator and specialist palliative care nurses were very accessible and actively engaged on the wards.

Access to services

The majority of patients were seen on the same day that they were referred to the specialist palliative care team or to the end of life care facilitator. At weekends and out of hours, advice was available from the specialist palliative care unit at Christchurch Hospital.

End of life care

Medical and nursing staff on the wards all said they had good access to the consultant in palliative medicine, the specialist palliative care nurses and the end of life care facilitator. The trust had a shared consultant on-call rota with the specialist palliative care unit at Poole Hospital, enabling 24-hour cover at all times. This helped ensure a responsive service was available at all times.

Discharge arrangements

The end of life care pathway was organised around each person's prognosis (life expectancy), whether they wished to return home, if they had family support, and whether they had specialist palliative care needs.

Patients with less than 48 hours to live, who wished to return home and had family support to do so, were put on the rapid discharge home to die pathway. These patients were discharged home within one working day.

Patients with specialist palliative care needs, or who deteriorated rapidly, and had less than two weeks to live were transferred to the palliative care unit at Christchurch Hospital. Patients with the same prognosis but no specialist palliative care needs were cared for at the Royal Bournemouth Hospital. These patients were put on the personalised care plan for last days of life and were seen by the hospital's end of life care facilitator.

Patients with more than two weeks to live, who wished to return home and had family support to do so, and who had no specialist palliative care needs were put on the community health care fast track pathway. They were discharged home or to a nursing home once suitable community packages of care were in place. We were told access to community packages of care varied locally. The average time taken to arrange a community package of care was four to five days, however it could take up to 10 days. Patients that had less than 2 weeks to live were transferred to their preferred place of death with the support of Christchurch Hospital palliative care unit hospice or home care team.

Delayed discharge

Around a third of end of life care patients died in the hospital while waiting to be discharged on the community health care fast track process. The consultant in palliative care medicine told us this was recognised as a high priority area by the local Clinical Commissioning Group. They said a review of community end of life care services and a report was due in January 2014. Delay in accessing community-based intensive packages of care was the main concern identified in the end of life care pathway.

Assessment

The hospital was piloting the use of Assessment, Management, Best Practice, Engagement, and Recovery uncertain care bundles (known as AMBER) on the Stroke Ward. It is a tool to assess and manage clinical care for patients who deteriorate rapidly and whose recovery is uncertain. It helps clinicians decide when a patient should receive full medical intervention or alternatively move to symptom control and end of life care.

Its aim was to identify earlier when a patient's condition deteriorated and end of life care was appropriate. If the patient deteriorated an escalation plan was agreed, which enabled quicker response to the patient's changing condition. The consultant in palliative medicine said the implementation of end of life care escalation plans presented a major training issue for consultants and doctors in training.

Are end of life care services well-led?

We found end of life care services were well-led.

Steering group

The trust's recently re-launched End of Life Steering Group aimed to drive change and facilitate education and training in end of life care. With the deputy medical director as chair, we were told this group was influential in raising the profile of end of life care at senior management and trust board level.

All clinical staff told us improvement in end of life care had become a major priority for the trust over the last 12 months. There were fundamental changes in the care pathways for patients at the end of life, including the appointment of an end of life care facilitator to support implementation of the new personalised care plans for end of life care and other initiatives.

Staffing

The consultant in palliative medicine led the trust's specialist palliative care team and associated services. They demonstrated great vision, energy and commitment

End of life care

to palliative care and end of life care services. They were clearly very highly regarded by other medical and nursing colleagues around the hospital, and had influence in the trust.

The specialist palliative care nurses and the end of life care facilitator demonstrated high levels of specialist knowledge about their roles and were passionate about ensuring good quality care for patients at the end of their life.

The end of life care facilitator worked closely with the palliative care team but the management and supervision arrangements for the end of life care facilitator were unclear and complicated. They reported to three different managers for different aspects of their role. We felt there was insufficient clinical supervision and support for this important role. It would benefit from becoming part of the trust's mainstream palliative care team structure.

Staff feedback

End of life care across the hospital was still a developing service. Many of the wards we visited were providing high standards of end of life care for patients and their relatives. We observed excellent leadership from a number of charge nurse/ward sisters on the wards visited. Staff said they were proud to work at the hospital and we observed a caring patient-focused culture on most of the wards we visited.

Feedback from clinical staff on the wards was very positive and they valued the support, training and advice provided by the end of life care facilitator. We were told the continuation of this post and the associated management arrangements are due for review by the trust in February 2014.

The trust was involved with the local Clinical Commissioning Group's review of end of life care services in the community. They were actively engaged with colleagues in the community to improve the pathway of care for people at the end of life. In this way, the trust was contributing to the leadership of end of life care services outside of their direct management control.

Outpatients

Information about the service

The hospital Outpatients Department (OPD) sees over 300,000 patients a year. Some patients visit the department for consultations or to undergo diagnostic tests such as endoscopies, X-rays and blood tests. Some minor procedures and investigations may also be carried out, such as biopsies. There are also clinics for prosthetics and appliances such as orthodontics.

The main OPD area consists of a central reception desk, waiting areas with facilities for light refreshments, male, female and disabled toilet facilities and clinical consultation and treatment rooms. The radiological services include X-ray services, ultrasound services, CT and MRI imaging and procedures undertaken under X-ray control.

We inspected the OPD services on 13 and 14 August 2014 to follow up concerns from previous inspection in October 2013. We visited the main OPD and attended various clinics. We talked to eight patients, We looked at health records, risk assessments, incident reports, and minutes from meetings, rotas and training records. We also spoke with 10 staff working in the various outpatient clinics and used information from staff focus groups.

Summary of findings

At inspection in October 2013 we found the outpatients department generally provided a caring and effective service for patients. There was much praise for the dedication of the staff. Feedback from patients was positive. The trust had not, however, been responsive about issues with waiting times and communication.

Individual clinics were well-led, with clinical staff taking responsibility for the organisation and arrangements as needed. However, quality assurance and risk management to ensure safety was not always supervised appropriately. There were infection control risks in the environment and staff were not clear about the measures in place to monitor infection control standards in the outpatient areas throughout the hospital.

At inspection in August 2014 there had been significant progress since our last inspection. We found that the trust had been responsive about issues with waiting times and communication. It had implemented a quality assurance and risk management system to ensure safety of patients. Infection control risks had been minimised by better cleaning rotas. The sluice room was de- cluttered and there were measures put in place to monitor infection control standards in the outpatient areas.

Outpatients

Are outpatients services safe?

At inspection in August 2014 we found improvements since October 2013 and the outpatients department was now safe.

Incident reporting

At the inspection in October 2013, staff told us that accidents had been investigated, but they could not find a Slips, Trips and Falls risk assessment for outpatients department (OPD). They said that although the reporting culture was improving, there wasn't enough time to complete work in clinics as well as the additional documentation associated with incident reporting.

At the follow up inspection in August 2014, we were shown the reporting systems for incident reporting. Forms were complete and there was a system in place to inform staff on actions taken as a result of the incident reported. We also checked staff meeting minutes and found formal records were kept. There was an action list which had people responsible to implement actions clearly identified. The OPD Operational Manager told us that information on incidents and actions taken was cascaded throughout the department. Staff told us that when they had reported incidents, feedback on actions taken was also given to them.

Risk management

The X-ray department had robust risk management processes in place, which worked well in practice. Staff told us about the systems and processes in place to reduce radiological risks. There was an open reporting culture, which was evident by the number of incidents reported and the resulting action taken to reduce risks. The Radiation Protection Committee met twice a year to discuss any incidents. We saw an example of where such an incident had been immediately escalated through the trust's Clinical Governance Group. After an urgent meeting, measures were quickly put in place to reduce the risk of recurrence.

Safeguarding

The trust's lead for Safeguarding Vulnerable Children told us that she was working with various outpatient departments throughout the hospital that saw and treated children. Training in safeguarding children was mandatory for all staff across the trust. The Safeguarding Children Group met quarterly and worked to ensure that staff were confident when dealing with suspected child abuse. We were told that the improved awareness of safeguarding had resulted in a higher number of referrals. Staff in the OPD clearly described the action they would take if they suspected child abuse, which included contacting the patient's GP. The trust had robust arrangements in place to safeguard children and vulnerable adults from abuse.

Infection control

At the inspection in October 2013, we found patients and staff were at risk of poor hygiene practices in the main outpatient department. At follow up inspection in August 2014 we found the department clean and tidy. There were cleaning rotas in place in toilets. There was twice daily cleaning of the toilets. However, we found that the times allocated for cleaning were not appropriate. We shared this concern with the Senior Sister in OPD who agreed with this and changed the timings to ensure continuous cleanliness.

The sluice room in the main OPD was de-cluttered. The OPD Operational Manager had put in measures to monitor infection control standards in the OPD departments throughout the hospital. They had taken the necessary actions to ensure the department was clean.

We observed there was limited availability and visibility of hand cleansing gel in the outpatient department.

Staffing

At the inspection in October 2013, we found that lack of trained OPD staff was challenging and had led to the cancellation of clinics; however, staff worked hard to reduce the impact on patients using the service. At follow up inspection in August 2014, we found there had been additional recruitment of staff to support clinics. Staff told us that whilst there were still some vacancies, staffing levels had improved.

Are outpatients services effective?
(for example, treatment is effective)

The outpatients department generally provided effective care.

Risk management

The Royal Bournemouth Hospital had systems intended to ensure that staff adhered to clinical guidelines and

recognised best practice through the Clinical Governance and Risk Management Group and staff training opportunities. At the inspection in October 2013, we found that such guidelines were not always followed.

At follow up inspection in August 2014, considerable work had been undertaken to ensure the department managed risk appropriately. There were now very clear accountabilities on the performance management of the department. The Operational Manager was responsible for non-clinical issues and the department had recruited a Head of Nursing and Quality who was going to be responsible for the overall clinical leadership of the department. The individual was going to start in October 2014. The department had also undertaken the Governance Audit tool (a generic health and safety risk assessment) in June 2014. There was an action plan that was being prepared.

Patient records

The clinical records completed in outpatients followed the patient through their care and treatment. The records were individual according to their care pathway. We looked at the urology screening and health questionnaire, which was completed during an outpatient appointment. This detailed the patient's medical, social and surgical history, and noted any allergies and lifestyle information. 'Baseline' observations were included in the patient's records, to be available when they were admitted for surgery. The records contained all the information required to ensure good communication between the patient and the healthcare professionals caring for them.

At the inspection in October 2013, we were told that record-keeping audits were not undertaken. At follow up inspection, we were shown record-keeping audits that had recently begun in August 2014. Staff told us there was a good system in place to ensure that the appropriate records were available for the right clinic.

Patient information and advice

At the inspection in October 2013, we found patients accessing outpatient services did not always have easy access to advice and information to inform their hospital visit. Information in the main OPD mostly concerned transport arrangements and making complaints.

At follow up inspection in August 2014, we found there was considerable more information and leaflets for people to access regarding various medical conditions.

At the inspection in October 2013, we noted that although 16% of the local population was of ethnic origin, we did not see any information in other languages or any information about how to access information in other languages.

At the follow up in August 2014 , we found that the trust had reviewed the provision of leaflets in other languages and found that there was no demand for it. There was, however, information on child protection and on how to access help or advice regarding children's centres.

Multi-disciplinary working

Outpatient services supported multi-disciplinary working and worked well in partnership with other departments and organisations to ensure the needs of their patients were properly managed and met. Staff told us how they worked with other departments in the hospital and with local GP surgeries and the ambulance service. Other outpatient services worked collaboratively within the community, depending on the speciality. For example, the Bournemouth Diabetes and Endocrine Centre (BDEC) service provided a community-based service for patients with new onset Type 2 diabetes. The service provided a foot care service and held joint clinics with the ophthalmology consultant.

Training

Staff received appropriate training and development to enable them to deliver safe and effective care. We spoke with the member of staff with responsibilities for overseeing the training and development of staff in the main outpatient department. Training records and files demonstrated that staff had opportunities to attend further training and development. The trust's annual training in subjects such as manual handling, fire prevention and infection control was mandatory.

Supervision and appraisals were managed by the staff member's immediate line manager and overseen by a clinical lead. Staff in diagnostics had more formal training and professional development opportunities, which were closely monitored by their line manager. We saw examples where staff were developing their skills and experience in new techniques such as diagnostic angiograms and reporting. There were systems in place to support staff training and development. Staff were supported through regular supervision and appraisals.

Outpatients

Are outpatients services caring?

The outpatients department is caring towards its patients.

Privacy

Staff generally respected patients' privacy and dignity. Treatment was provided in single consulting or treatment rooms and most staff were mindful of protecting patients' privacy. Staff told us they were aware that the main OPD reception desk was open to the public and it was difficult to maintain confidentiality. They told us that if needed, they would use an empty room for a confidential or sensitive discussion. However, this didn't always happen. In the Diabetic and Endocrine Clinic we saw a clinician discussing personal information with a patient with the door open. This did not respect the patient's privacy or confidentiality.

Responding to feedback

There were many opportunities for patients to feed back their experiences of the outpatient department, such as comment cards and details of the complaints process, which were readily available. Staff welcomed their input and used this to improve the service offered. An example was where a patient had noted in the comments book in reception that there were no facilities for fathers to change babies' nappies. Following this, baby changing facilities had been added to the disabled toilets.

Complaints

When asked how complaints were managed, the deputy manager showed us a complaints/incidents calendar and said that complaints were usually given to the Clinical Team Leaders to investigate, and then any learning was fed back at staff meetings or individually. An example was where improving communication was required when a clinic was running late.

Feedback from patients

Patients told us the reception staff were always helpful and provided clear information and advice. All the patients we talked to said they felt listened to and fully involved in their care and treatment. One patient attending the Orthopaedic Clinic told us it was "an exceptional service." Patients told us they didn't feel rushed. Another patient attending a pre-admission clinic told us that the nurses were kind and friendly and helped to reassure them about the admission process. All the people who spoke with us praised the dedication of the staff, telling us they were very friendly and caring with "excellent" attitudes, which gave them confidence and reassurance in their care and treatment. This demonstrated the outpatient service was patient-focused.

Are outpatients services responsive to people's needs?
(for example, to feedback?)

At inspection in October 2013 we found the outpatients department was not always responsive to people's needs.

At follow up inspection in August 2014 we found that improvements had been made and there was a better patient experience.

Availability

The Outpatients Department (OPD) had expanded the service it offered and was now at capacity for the space and staff available. Main outpatient services did not usually operate in the evening or at weekends; although staff told us that they had on occasion undertaken clinics outside of the normal opening hours in response to an identified need. They gave examples of weekend clinics to deal with a backlog of surgical patients, and where patients in a breast screening recall had been asked to attend the hospital urgently. The X-ray department was now providing seven-day cover in response to a growing need for out-of-hours demand and reporting. This is an example of responding to the needs of the population using OPD

Waiting times

At the inspection in October 2013, we found that the booking process was not always patient-focused and sometimes led to patients experiencing unnecessarily long waiting times. We spoke with patients about the long waiting times that often happened throughout the outpatients services. At the inspection in August 2014 we found that the booking process had improved. The clinic would not additional book patients just in case patients did not attend. We found waiting times for blood tests in the Pathology Department had improved. We spoke with two patients who told us that there were no long delays in giving blood for tests.

Outpatients

Communication

At the inspection in October 2013 some patients told us that the information on the appointment letter was not clear or accurate. At the follow up inspection in August 2014 we spoke with four patients and found they had all received the correct information.

Are outpatients services well-led?

The inspection in October 2013 found the outpatients department was not consistently well-led. At follow up inspection in August 2014 we found the leadership of the department had improved and had taken steps to improve the service.

Risk management

At the inspection in October 2013, we found there were no infection control audits. We had concerns that infection control was not being monitored effectively. At follow up inspection in August 2014, we found the leadership had introduced daily infection control checks and monthly infection control audits.

Views of staff

At the inspection in October 2013, most staff told us that although it was stressful, they felt the OPD was a good place to work. At follow up inspection in August 2014, we were told that there had been some additional staff brought in to support the work of the OPD. Nursing staff were looking forward to the arrival of the new Head of Nursing and Quality. Nurses felt that this would provide appropriate clinical leadership to the department and a voice for nurses working in the department.

Good practice and areas for improvement

Areas of good practice

Our inspection team highlighted the following areas of good practice in October 2013:

- Some aspects of end of life care were undertaken very well.

Our inspection team highlighted the following areas of good practice in August 2014:

- The multi-disciplinary team called OPAL (Older Persons Assessment Liaison) provided specialist and highly effective support to those requiring complex discharge arrangements.

Areas in need of improvement

Action the hospital MUST take to improve

We set compliance actions following inspection in October 2013. At follow up inspection August 2014 we found these compliance actions had been met as follows:

- All patients need to have their needs assessed and care delivered safely and in a timely manner by staff who are skilled to do so. At follow up inspection August 2014 we found on-going improvements to assessment, planning and delivery of care. This was supported by the appointment of clinical matrons and practice development nurses.
- At all times, patients must be treated with the dignity and respect they deserve and basic care needs must be met. At follow up inspection August 2014 we found action had been taken and patients were treated with dignity and respect and received care that met their needs.
- The trust must reassure itself and stakeholders that all opportunities to drive quality improvement and quality assurance are taken.
- At follow up inspection August 2014 we found a clear commitment to quality improvement at all levels of the organisation and more robust quality assurance processes.
- The trust must ensure that the required number of staff with the correct skills are employed and managed shift by shift, to demonstrate that there are sufficient staff to meet people's needs.
- At follow up inspection August 2014 we found the trust had taken significant steps to recruit sufficient staff and this was an on-going commitment.

Action the hospital COULD take to improve

In October 2013 we identified actions the hospital could take to improve. At inspection August 2014 we found the following actions had been taken:

- The stroke pathway before patients are admitted to the stroke ward. At follow up inspection in August 2014 we found this action had been met, through the introduction of a more streamlined stroke pathway. However, the provision of specialist medical assessment and treatment of stroke patients admitted to the stroke ward out of hours could be improved.
- Levels of nursing staff in wards, especially those caring for the frail elderly patients, did not reflect the dependency of patients. This meant there was a high risk and actual occurrences of patients not receiving the care they needed in a timely manner. At follow up inspection August 2014 we found the trust had taken steps to monitor staffing levels in relation to the dependency of patients. Additional staff were provided when required to meet the needs of patients.
- Care planning and evaluation did not contain all relevant information and staff on duty did not always know the specific care needs of people. At follow up inspection August 2014 we found some improvements and monitoring of care planning, along with support for newly recruited staff.
- Staff had not all attended mandatory training within the stated timeframe and/ or were not suitably trained for the areas in which they may work, for example, in dementia care, and to perform the necessary tests to assess whether a patient is able to swallow. At follow up inspection August 2014 we found that staff had attended appropriate training. Support from Clinical matrons and practice development nurses, and more clinical time for ward sisters provided support for staff in developing the necessary knowledge and skills.
- Security arrangements in A&E previously left staff feeling vulnerable. At follow up inspection August 2014 we found more robust security arrangements in place, although staff wanted continued consideration of developing an in-house security team.

Good practice and areas for improvement

- Escalation beds in AMU and A&E were considered dangerous and not fit for purpose. At follow up inspection in August 2014 we found that escalation beds were no longer used.
- Junior medical staff in surgical services required more support out of hours. At follow up inspection August 2014 we found actions had been taken and junior medical staff were well supported.
- Patients did not always have informed consent by doctors who were fully aware of procedures. At follow up inspection August 2014 we found actions had been taken and improvement in staff understanding.
- The mental health care pathway in A&E was not a 24-hour service. At follow up inspection August 2014 we found actions to address this had been taken since the last inspection. However a pilot of additional mental health support was no longer funded and the pathway could be improved yet further.
- A&E did not always provide care for children from suitably-qualified staff at all times. At follow up inspection August 2014 we found actions had been taken to recruit more staff. However, the trust continued to have some concerns about admitting patients aged 16-18 years as there was not inpatient paediatric support at the hospital.
- Records for care and for incidents were not always completed in full and timely manner. At follow up inspection August 2014 we found appropriate actions had been taken and there was on-going monitoring and support provided to improve the accuracy of records.
- The outpatient booking process was not always patient-focused and sometimes led to patients experiencing long waiting times. At follow up inspection August 2014 we found actions had been taken to reduce unnecessary waits.

At inspection in August 2014 we found the hospital SHOULD take the following actions to further improve:

- The trust should increase privacy for patients in A&E Majors department by providing frosted glass or privacy film to the externally facing windows in cubicles.
- The trust should take action to improve the service for stroke patients in line with national benchmarking for stroke patients, particularly for those patients admitted at weekends or out of hours.
- The trust should ensure that for patients who require their fluid intake and/or output to be monitored that this is accurately recorded.
- The trust should ensure that the records of checks of essential equipment are accurately and consistently recorded on ward areas.
- The Alzheimer's Society booklet 'This is Me' should be completed for patients living with dementia.
- The trust should take action to improve the mental health care pathway in A&E which is not yet a 24-hour service.
- The trust should work with commissioners to clarify admission criteria and suitable locations for 16-18 year olds requiring admission to hospital from the A&E department.
- The trust A&E department should consider a more robust checking procedure of ensuring that transfer equipment is routinely returned to its' base and left in a clean and charged condition ready for immediate use when necessary.
- The trust should take action so that nursing staff who have the skills to provide an outreach stroke service to patients on other wards of the hospital are able to provide this service.
- The availability and visibility of hand cleansing gel in the outpatient department should be improved.