Care Quality Commission

Royal United Hospitals Bath NHS Foundation Trust

Royal National Hospital for Rheumatic Diseases

Quality Report

Upper Borough Walls
Bath
BA1 1RL
Tel: 01225 465941
Website: www.ruh-tr.heriatge@nhs.net

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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.

Ratings

Overall rating for this hospital	Requires improvement
Medical care (including older people's care)	**Requires improvement**
Outpatients and diagnostic imaging	**Good**

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out a comprehensive and announced inspection of the Royal National Hospital for Rheumatic Diseases between 15 and 18 March 2016, as part of our comprehensive inspections programme of all acute NHS trusts.

The Royal National Hospital for Rheumatic Diseases is a registered location and provides medical, children's and outpatient services. We did not inspect the children's services as part of this inspection.

We rated the Royal National Hospital for Rheumatic Diseases (RNHRD) as requires improvement overall. There were improvements needed in safety, responsiveness and leadership in the medicine (including older people's care) service, which was requires improvement overall. The outpatient service was rated as good.

Our key findings were as follows:

Safe:

- Patients admitted to the medical ward with complex needs did not have care plans in place to provide the staff with detailed information and guidance regarding their care and treatment needs.
- Patient monitoring records and charts were not fully or consistently completed.
- It was not clear that correct procedures had been consistently followed when staff identified safeguarding concerns in relation to patients admitted to the ward.
- Patients admitted to the ward were screened for infections prior to being admitted to the ward. However, the results from the screening test were not stored in the notes held on the ward but returned to medical records. This meant there was a risk that the promotion and control of infection on the ward would not be effective.
- Not all staff had completed their mandatory training.
- There was not a clear system in place to provide consultant cover for medical patients who were transferred from the Royal United Hospital (RUH).

However:

- Staff understood their responsibilities and were encouraged to report incidents and events which could potentially cause patients harm. Learning was taken from such incidents to reduce the risk of similar events reoccurring. Information had been provided to staff regarding Duty of Candour and staff were aware of the principles of the legislation.
- The safety thermometer information showed patients generally experienced harm free care on the ward
- The ward was hygienic and staff demonstrated a good understanding of the promotion and control of infection.
- Medicines were managed appropriately and stored securely.

Effective:

- Staff provided care and treatment in line with the trusts policies and procedures and national guidelines.
- Patients were offered support with their meals and additional snacks and drinks were available to patients at all times.
- Staff were encouraged to undertake role specific training to ensure they were competent and provided a high standard of care and treatment.
- Multi-disciplinary team working was effective and at times outstanding at the hospital.

However:

- Not all services were operational over seven days. Patients did not have routine access to therapy, x-ray and medical staff out of hours. There was no clear pathway for medical patients to be seen or reviewed by a consultant.
- Not all staff demonstrated a clear understanding of the Deprivation of Liberty Safeguards.

Summary of findings

Caring:

- Feedback from patients and/or their representatives was consistently positive about the manner in which staff treated them.
- We observed staff were kind, compassionate and showed empathy to those they cared for and provided a service to.
- Patients were provided with sufficient information and support to help them understand their care and treatment plans and options available to them.

Responsive:

- At times the medical patients transferred from RUH did not always meet the criteria in place and their care needs were complex and impacted upon patients already on the ward. There was limited therapy support for these patients.
- The ward did not fully meet the care needs for patients who lived with dementia. However the admission criteria was clear that patients with dementia should not be transferred to the hospital but was not always followed.
- There was a delay in follow up appointments for patients.

However:

- Patients were provided with appointment dates promptly when assessed as requiring admission to the ward to take part in a pain management programme.
- Services were developed in response to patient need for example, the fibromyalgia service.
- The facilities and environment offered access to patients with disabilities.
- Patients knew how to make a complaint and complaints were responded to appropriately by the trust.

Well Led:

- The trust had acquired the RNHRD in February 2015. Governance systems had been put in to place and in some areas were working well, in others they had not fully embedded.
- There was limited monitoring and quality measurement of the care and treatment records maintained for patients on the ward. There were significant gaps in the care records which had not been identified or addressed.

However:

- There was a positive culture at the hospital and staff were proud of the service they delivered to patients
- There was clear local leadership in the hospital and staff were confident and able to approach the hospital manager for support and guidance when necessary.
- Not all staff saw their line manager regularly and sought support from other managers on site when needed.
- Staff meetings were held regularly to enable information to be shared and staff to be updated.

We saw several areas of outstanding practice including:

- The hospital had been passed the criteria to be recognised as a centre of excellence for lupus
- The hospital had received national recognition by the Health Service Journal as the best specialist place to work in 2015.
- Staff worked well as a multi-disciplinary team throughout the hospital. We saw outstanding team working during a multi-disciplinary team meeting we attended. The patient was at the centre of the meeting, with all professionals striving to promote the health and wellbeing of the patient.
- Patients could attend the RNHRD either as inpatients or staying nearby in self-contained flats, dependent on their care needs and independent living skills. The patients who stayed on the ward were provided with care from the nursing staff. The psychologists who led the pain management programmes provided nursing staff with informal training regarding the philosophy of the programme and how to support patients with their treatment.

Summary of findings

- The Fibromyalgia service had been developed in response to patient need and was now being set up to become a franchised model to share the programme with other trusts.
- The Complex Regional Pain Syndrome (CRPS) service held a weekly multidisciplinary meeting. We attended this meeting during our inspection and found the content and style of the meeting to be outstanding.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- The trust must ensure care records and documentation such as risk assessments, referrals to other professionals and clinicians, care plans and monitoring records such as food and fluid charts are in place. The records should be in sufficient detail and maintained appropriately to direct and inform staff on the action they must take to meet the care and treatment needs for patients.
- The trust must ensure that appropriate medical care is provided for patients transferred to the RNHRD from the medical wards at RUH.

In addition the trust should:

- The trust should ensure that staff have access to up to date information on the patient's infection status in particular in relation to MRSA.
- The trust should ensure robust procedures are put in place for ensuring the promotion and control of infection regarding the routine steam cleaning of the ward and equipment.
- The trust should encourage all staff to complete incident reports themselves.
- Staff should have access to feedback following the reporting of incidents to ensure that learning takes place after an incident.
- The trust should ensure that records demonstrate the action taken when safeguarding concerns are identified.
- The trust should ensure that patients and visitors to the hospital can easily find their way to all departments.
- The trust should ensure that patients can access hand washing facilities in every toilet.
- The trust should ensure that fluids for intravenous infusion are not accessible to patients and visitors to the ward.
- The trust should ensure that the mandatory training is kept up to date for all staff.
- All equipment should be serviced, maintained and/or calibrated to ensure it was fit for purpose and ready to use.
- The trust should ensure all staff were confident and competent to use emergency equipment when necessary.
- All staff should be trained and competent to use emergency evacuation equipment.
- The trust should ensure that patient's medical care and treatment needs can be met at the RNHRD before transfers are arranged. The transfer criteria should be complied with.
- The trust should look to reference the guidance by The Law Society in its policy relating to deprivation of Liberty, and ensure there is flexibility within the policy when applying the 72-hour rule.
- The trust should ensure governance systems continue to be embedded.
- The trust should ensure monitoring and quality measurement of the care and treatment records is in operation.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Medical care (including older people's care)	Requires improvement 	We have judged medical services at the Royal National Hospital for Rheumatic Diseases (RNHRD) overall, as requiring improvement. There were some areas judged as requiring improvement for safety, responsive and well led because: • Patients admitted to the medical ward with complex needs did not have care plans in place to provide staff with detailed information and guidance regarding their care and treatment needs. • Patient monitoring records and charts were not fully or consistently completed. • It was not clear that correct procedures had been consistently followed when staff identified safeguarding concerns in relation to patients admitted to the ward. • Admitted patients were screened for infections prior to being admitted to the ward. However, the results from the screening tests were not stored in the notes held on the ward but returned to medical records. This meant there was a risk infection control on the ward would not be effective. • It was not clear that there were robust procedures in place for ensuring the promotion and control of infection regarding the use of material curtains in clinical areas. • Fluids for intravenous infusion were stored in an unlocked cupboard in an area which was accessible by the public. This meant they were not tamper proof. • Not all staff had completed their mandatory training. • There was no clear system in place to provide consultant cover for medical patients who were transferred from the Royal United Hospital (RUH). • Some patients experienced a delay in being provided with an outpatients appointment. • At times the medical patients transferred from the RUH did not always meet the criteria in

Summary of findings

place and at times, their care needs were complex and impacted upon patients already on the ward. There was limited therapy support for these patients.

- The ward did not fully meet the care needs for patients living with dementia. Whilst the admission criteria was clear that patients living with dementia should not be transferred to the hospital, there were patients transferred to the RNHRD who were living with dementia.
- Governance, quality monitoring and risk management had been reviewed and developed when the hospital was acquired by the trust. The systems were still embedding at the time of our inspection.

However we have judged the service provided an effective and caring service to patients because:

- Staff were encouraged and confident to report incidents and concerns and we saw action had been taken to address reported issues.
- The safety thermometer showed good outcomes for the patients admitted to the ward.
- Staff followed the trusts infection control procedures and provided a hygienic environment for patients.
- Medicines were managed safely and patients were supported to self-administer their medicines where possible.
- Personal and confidential records were stored securely within the hospital and ward.
- Staffing levels were assessed using a nationally recognised tool and additional staff were on duty to meet the complex needs of some patients on the ward.
- Care and treatment was provided in line with national guidelines and good practice recommendations.
- Staff were kind and caring to patients and showed empathy and understanding when talking with and caring for them.
- The Friends and Family Test results were positive with the majority of patients stating they would recommend the service.

Summary of findings

- Multidisciplinary team working was apparent in the hospital between all members of staff. There was an open and friendly culture towards working with colleagues.
- Information was available for patients within the hospital regarding their care and treatment needs.
- There were low numbers of complaints made to the trust regarding the service provided at RNHRD but when a complaint was made, staff listened and took appropriate action to address the issue.

Outpatients and diagnostic imaging

Good

We judged the outpatients services at the Royal National Hospital for Rheumatic Diseases as good overall.

- Staff were encouraged and were confident to report incidents via the trust's electronic reporting system.
- Information had been provided to staff regarding Duty of Candour and staff were aware of the principles of the legislation.
- The outpatients department was clean and hygienic and staff promoted the control of infection.
- Medicines were managed appropriately and stored securely.
- Patients were safeguarded against harm by staff who had completed training and had access to policies and procedures.
- Policies, procedures and practices within the hospital were in accordance with national guidelines and best practice recommendations.
- Staff worked well within multidisciplinary teams in the hospital. Good working relationships were forged with external professionals.
- Staff were aware of the requirement for consent to be obtained prior to the provision of care and treatment to patients.
- Patients received care and treatment from staff who were kind, caring and showed empathy and understanding.
- Friends and Family Test results were positive with the majority of patients stating they would recommend the service.

Summary of findings

- The hospital had been accredited as a centre of excellence for Lupus care and treatment.
- The hospital had been awarded the best place to work in the Health Service Journal awards 2015.
- The trust engaged with the staff and consulted and informed them on the plans to transfer services to the main Royal United Hospital (RUH) site.

However:

- There was a delay for some patients waiting for follow up appointments.
- It was not clear that the governance pathways put into place since the RNHRD had been acquired by the RUH NHS trust were fully embedded and effective.

Royal National Hospital for Rheumatic Diseases

Detailed findings

Services we looked at
Medical care (including older people's care) and Outpatients & Diagnostic Imaging

Detailed findings

Contents

Background to Royal National Hospital for Rheumatic Diseases

The Royal National Hospital for Rheumatic Diseases (RNHRD) is located in the centre of Bath.

The hospital had been acquired by the Royal United Hospital Trust in February 2015, prior to that it was a separate organisation. We inspected medical and outpatient services at the RNHRD as part of a comprehensive inspection of the trust.

There were a number of clinics held at RNHRD for children and young people. There were plans in place to relocate these services to the Royal United Hospital location. The clinical support for the services was from paediatricians who were based at a local specialist children's hospital. There was a service level agreement between the trusts regarding their secondment to the RNHRD for the purpose of the clinics. We did not inspect children's services on this inspection.

The hospital provided 22 inpatient beds located on the Violet Prince Ward primarily for the care and treatment of rheumatology patients and patients completing pain management programmes.

Specialist services provided at the RNHRD included the biologics day unit (650 patients), the complex regional pain syndrome service, breast radiotherapy injury rehabilitation service, Bath centre for pain services, ankylosing spondylosis service (approx. 1000 patients), the fibromyalgia self-management service, and the chronic fatigue service. These services were operated and managed from the RNHRD. Patients were able to attend treatment programmes as out patients and stay in local accommodation arranged by the hospital based on a satisfactory risk and care needs assessment.

Patients accessed the hospital from the local area, from other parts of the country and internationally.

Our inspection team

Our inspection team was led by:

Chair: Matthew Kershaw, Chief Executive, East Kent Hospital University Foundation Trust

Head of Hospital Inspections: Mary Cridge, Care Quality Commission

The team included CQC inspectors and a variety of specialists: consultant geriatrician, governance lead nurse, occupational therapist and an expert by experience.

Detailed findings

How we carried out this inspection

Prior to the inspection we reviewed a range of information held about the hospital and asked other organisations to share what they knew about the hospital. These organisations included Healthwatch, the local Commissioning Care Groups and Monitor.

We requested a variety of data from the trust to demonstrate their performance rates.

We carried out an announced inspection between the 15 and 18 March 2016.

We held two drop-in sessions to which all members of staff in the hospital were invited. Five staff attended over the two days. During the course of our inspection we spoke with 53 members of staff, including nurses, specialist nurses, managers, junior doctors, consultants, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, staff side representatives, domestic staff and porters.

We talked with 31 patients and 12 of their friends/family who were attending the hospital either as outpatients or staying on the ward. We observed how people were being cared for and reviewed the medical and nursing records regarding the care and treatment for 15 patients.

Facts and data about Royal National Hospital for Rheumatic Diseases

The Royal United Hospital Bath Foundation Trust has 772 beds across its sites. It provides care and treatment to a population of around 500,000 across Bath, North East Somerset and Wiltshire. Between January 2015 and December 2015 there were 84,307 inpatient admissions, 803,566 outpatient attendances and 79,574 attendances at the emergency department.

In 2014/15 financial year, the trust had a revenue of £272.7m, of which the full cost was £270.5m which resulted in a surplus of £2.2m. The trust had previously made significant improvements from a historic challenging financial position; a working capital loan of £38 million was taken in 2007 and repaid in full in 2012.

As of December 2015, the trust employed 5,539 staff (4,375 whole time equivalents), of whom 5% were bank, agency or locum.

The trust had a stable board, with the most recent executive appointments being the director of nursing and finance directors in 2013. The chief executive had been in post since 2007. The six non-executive directors had also been appointed for some time, most prior to 2012 with one new non-executive being appointed at the end of 2015. At the time of our inspection the chief executive had been appointed as the senior responsible officer for the Bath and North East Somerset, Swindon and Wiltshire Sustainability and Transformation Plan.

The Royal National Hospital for Rheumatic Diseases is a registered location of Royal United Hospitals Bath NHS Trust. It provided care and treatment for patients requiring medical inpatient care and outpatient services primarily regarding pain management and rheumatology. Services for children were provided within the outpatients service.

The hospital had not been inspected since being acquired by the Royal United Hospitals Bath NHS Foundation Trust.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Notes

Medical care (including older people's care)

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

The Royal National Hospital for Rheumatic Diseases (RNHRD) provided medical inpatient services for up to 22 patients on Violet Prince Ward. Patients were admitted to the ward for care and treatment of rheumatology illnesses. Patients were also admitted through the pain management and chronic fatigue services at the hospital.

We carried out an announced inspection between 15 and 18 March 2016 as part of our planned comprehensive inspections of NHS trusts. During the inspection we observed how people were being cared for and reviewed the medical and nursing records regarding the care and treatment for 15 patients. We talked with 31 patients and 12 of their friends/family who were attending the hospital.

We held two drop-in sessions to which all members of staff in the hospital were invited. Five staff attended over the two days. During the course of our inspection we spoke with 53 members of staff, including nurses, specialist nurses, managers, junior doctors, consultants, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, staff side representatives, domestic staff and porters.

We talked with 31 patients and 12 of their friends/family who were attending the hospital either as outpatients or staying on the ward.

Summary of findings

We have judged medical services at the Royal National Hospital for Rheumatic Diseases (RNHRD) overall as requiring improvement.

There were some areas judged as requiring improvement for safety, responsive and well led because:

- Patients admitted to the medical ward with complex needs did not have care plans in place to provide staff with detailed information and guidance regarding their care and treatment needs.
- Patient monitoring records and charts were not fully or consistently completed.
- It was not clear that correct procedures had been consistently followed when staff identified safeguarding concerns in relation to patients admitted to the ward.
- Admitted patients were screened for infections prior to being admitted to the ward. However, the results from the screening tests were not stored in the notes held on the ward but returned to medical records. This meant there was a risk infection control on the ward would not be effective.
- It was not clear that there were robust procedures in place for ensuring the promotion and control of infection regarding the use of material curtains in clinical areas.

Medical care (including older people's care)

- Fluids for intravenous infusion were stored in an unlocked cupboard in an area which was accessible by the public. This meant they were not tamper proof.
- Not all staff had completed their mandatory training.
- There was no clear system in place to provide consultant cover for medical patients who were transferred from the Royal United Hospital (RUH).
- Some patients experienced a delay in being provided with an outpatients appointment.
- At times the medical patients transferred from the RUH did not always meet the criteria in place and at times, their care needs were complex and impacted upon patients already on the ward. There was limited therapy support for these patients.
- The ward did not fully meet the care needs for patients living with dementia. Whilst the admission criteria was clear that patients living with dementia should not be transferred to the hospital, there were patients transferred to the RNHRD who were living with dementia.
- Governance, quality monitoring and risk management had been reviewed and developed when the hospital was acquired by the trust. The systems were still embedding at the time of our inspection.

However, we have judged the service provided an effective and caring service to patients because:

- Staff were encouraged and confident to report incidents and concerns and we saw action had been taken to address reported issues.
- The safety thermometer showed good outcomes for the patients admitted to the ward.
- Staff followed the trusts infection control procedures and provided a hygienic environment for patients.
- Medicines were managed safely and patients were supported to self-administer their medicines where possible.
- Personal and confidential records were stored securely within the hospital and ward.
- Staffing levels were assessed using a nationally recognised tool and additional staff were on duty to meet the complex needs of some patients on the ward.
- Care and treatment was provided in line with national guidelines and good practice recommendations.
- Staff were kind and caring to patients and showed empathy and understanding when talking with and caring for them.
- The Friends and Family Test results were positive with the majority of patients stating they would recommend the service.
- Multidisciplinary team working was apparent in the hospital between all members of staff. There was an open and friendly culture towards working with colleagues.
- Information was available for patients within the hospital regarding their care and treatment needs.
- There were low numbers of complaints made to the trust regarding the service provided at RNHRD but when a complaint was made, staff listened and took appropriate action to address the issue.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

We judged medical services as requires improvement for safety because:

- Patients admitted to the medical ward with complex needs did not have care plans in place to provide the staff with detailed information and guidance regarding their care and treatment needs.
- Patient monitoring records and charts were not fully or consistently completed.
- It was not clear that correct procedures had been consistently followed when staff identified safeguarding concerns in relation to patients admitted to the ward.
- Admitted patients were screened for infections prior to being admitted to the ward. However, the results from the screening test were not stored in the notes held on the ward but returned to medical records. This meant there was a risk that the promotion and control of infection on the ward would not be effective.
- It was not clear that there were robust procedures in place for ensuring the promotion and control of infection regarding the routine steam cleaning of the ward and equipment.
- Fluids for intravenous infusion were stored in an unlocked cupboard in an area which was accessible by the public. This meant they were not tamper proof.
- Not all staff had completed their mandatory training.
- There was no clear system in place to provide consultant cover for medical patients who were transferred from the Royal United Hospital (RUH).

However:

- Staff understood their responsibilities and were encouraged to report incidents and events which could potentially cause patients harm. Learning was taken from such incidents to reduce the risk of similar events reoccurring.
- The safety thermometer information showed patients generally experienced harm free care on the ward.
- The ward appeared clean and hygienic and staff demonstrated a good understanding of the promotion and control of infection.
- Patients were supported to manage their own medicines whenever possible. Medicines were managed safely and appropriately on the ward.
- Patients' confidential and personal records were stored securely in the hospital.

Incidents

- Staff were aware of the process in place to report incidents and near miss incidents. We received a variable response from staff we spoke with regarding what was a reportable incident. Registered nurses told us they were confident to report an incident using the trust electronic reporting system and provided information regarding incidents they had reported. For example, when a patient experienced an injury such as following a fall or administrative errors such as misfiling of medical records. However, not all staff were clear about what constituted an incident and when they would report. We spoke with three health care assistants who said they did not report via the electronic system but would raise any concerns with the nurse in charge. They assumed the nurse would then report the incident but were not clear on whether this had happened and how they should get feedback about the incident.
- Once an incident had been reported, the electronic system flagged the incident to the sister in charge of the ward and the hospital manager to ensure they were aware of each incident. Additional senior staff, for example the divisional managers, were also informed of the incident depending on the nature of the incident and the severity of potential harm to patients and/or staff.
- Staff told us they did not always get feedback regarding the incidents they reported. The electronic system enabled the user to request feedback but if they did not do this at the time of reporting they would not receive feedback. This did not ensure learning from incidents and reduce the risk of incidents recurring.
- However, we were given information that learning was taken from incidents which happened at the Royal National Hospital for Rheumatic Diseases (RNHRD). An example provided was of an incident regarding a patient who self-medicated. A root cause analysis had been completed following the reported incident and practice had changed to protect patients. The change had

included closer monitoring of the referrals made to the hospital and that patients who took specific medication were not seen by clinicians without their full medical records being available.

- The incidents reported at RNHRD were monitored to establish if there were themes or trends. The majority of reported incidents were in response to patient falls. Across the trust and including RNHRD, there had been action taken to reduce the number of falls experienced by patients. The actions included lead clinicians with responsibility for falls appointed in each area, 'falls meetings' at the Royal United Hospital (RUH) and changes in documentation such as the introduction of an electronic falls bundle and specific risk assessments. The falls bundle is a set of interventions that, when used together, significantly improve patient outcomes.
- Learning from incidents which had occurred in the wider trust was shared at division management and governance meetings, and changes in practice would be shared with the staff at the RNHRD. We were shown an email which contained feedback to staff on how to reduce the risk of an incident which had previously occurred in the trust.
- The hospital manager was copied into all investigations into serious incidents at the RUH and was involved with the investigation of incidents at RNHRD. The outcomes and learning from such incidents were discussed at the divisional and governance meetings and subsequently shared with staff. There had been one serious incident at RNHRD in the past year which was regarding a fall. A full investigation had been completed and an action plan developed which addressed the recommendations and findings of the investigation.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a regulation which was introduced in November 2014. This Regulation requires the trust to notify the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.
- The trust had nominated a lead member of staff for duty of candour issues and they were based at the RUH site. Clinicians had been provided with documentation from the trust and the topic was discussed at postgraduate induction sessions and medical staff meetings.
- The hospital manager had raised awareness of duty of candour requirements amongst the nursing staff during team meetings. Therapists told us they had been provided with information at their staff meetings.
- There had been no formal training provided by the trust regarding duty of candour according to the staff we spoke with. However, the trust provided us with evidence in the form of an email, which showed a 45 minute training session had been planned for staff at the RNHRD in March 2016.
- The understanding of duty of candour responsibilities was variable amongst the staff we spoke with. Not all nursing and medical staff were aware of the terminology duty of candour but were able to explain the process and philosophy.
- An example was given following an incident when the duty of candour process was followed. Staff acknowledged that the process was not finalised with a written letter to be sent to the patient. However, the trust advised us following the inspection that the letter had been sent at the time of the inspection but the staff would not have known this.

Safety thermometer

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. The performance indicators used in the Safety Thermometer showed 100% of venous thromboembolism (VTE) assessments had been completed for patients since May 2015. A VTE is a blood clot within a vein. There had been a concern in April 2015 that only 67% of VTE assessments had been completed but this had been addressed by providing reminders to the staff.
- The performance indicators showed that there had been no pressures ulcers on the ward for the previous year up until February 2016 where three patients were admitted to the ward with a pressure ulcer. During this period 97% of risk assessments relating to pressure ulcers were completed.
- The performance indicators monitored the number of patients with urinary catheters and any associated urinary tract infections. There had been one catheter associated urinary tract infection over the previous year.
- The number of falls on the ward was recorded and monitored by the trust. We saw where there had been

falls which resulted in harm to the patient an investigation took place by the trust. The investigation resulted in an action plan if it was deemed preventative measures could have reduced the risk of the fall.

Cleanliness, Infection and hygiene

- The patient led assessments of the care environment (PLACE) were completed by teams of local people who reviewed how the care environment supported patients. The assessments of the environment scores for 2015 showed the Royal National Hospital for Rheumatic Disease (RNHRD) were similar to the England national averages for the condition and appearance of the environment.
- Staff had electronic access to the trust infection control policies and procedures. Staff confirmed they had completed their infection control training during their induction to the trust.
- Information displayed on the ward and data provided to us prior to the inspection demonstrated that in the last year, there had been no incidences of Clostridium difficile (C. diff or C. difficile), methicillin-susceptible Staphylococcus aureus (MSSA) or methicillin-resistant Staphylococcus aureus (MRSA). MRSA is a type of bacteria that is resistant to a number of widely used antibiotics which means that MRSA infections can be more difficult to treat than other bacterial infections.
- Patients were tested for MRSA and MSSA prior to being admitted to the hospital, before transfer from the Royal United Hospital (RUH) and also on arrival at the RNHRD. The multidisciplinary notes on the ward identified the date that tests were taken at the RNHRD. However, the results were not recorded in these notes. There was a prompt available in the notes to record the date the test was taken and the outcome, but the result was left blank. Medical staff told us they received the results from the laboratory and informed the nursing staff verbally of any positive findings. The paper results form was returned to medical records for filing. This did not ensure a formal system was followed to promote the control of infection in the ward. Following the inspection the trust informed us that any positive results were recorded in patient notes but this was not the system that staff informed us of during the inspection. Staff did however confirm they were unaware of any patients with an infection on the ward at the time of our inspection.
- Domestic staff were employed by the trust with a consistent team working at RNHRD. All of the areas we visited appeared clean and hygienic. There were plentiful supplies of cleaning materials.
- The cleaning materials were managed within the Control of Substances Hazardous to Health (COSHH) legislation. We observed that when COSHH materials were unattended by staff they were stored in locked cupboards within a sluice which had a key pad entry system. This prevented unauthorised people accessing the cleaning materials.
- Handwashing facilities were in place throughout the ward with soap and antibacterial gel available for use by staff, patients and visitors. Notices were displayed regarding effective hand hygiene to assist in the control of infection.
- Staff were observed to wash and gel their hands regularly. Patients confirmed staff washed their hands before providing care and treatment to them.
- Personal protective equipment such as gloves and aprons were located throughout the ward and we saw the dispensers for these were kept well stocked throughout our visit.
- Sharps bins were in place in all clinical areas for the disposal of equipment which could cause transference of infection and harm to staff and patients. For example, used needles and instruments which could break or pierce the skin. The sharps bins were used in accordance to manufacturer's guidelines and were not overfilled and the lids were kept closed when not in use.
- The trust employed a number of infection control specialist nurses. We met with one of the specialist nurses who visited the ward for the routine weekly visit. The nurse stated they visited the RNHRD each week to monitor the ward and outpatients' environment and equipment for patient use to ensure high standards of cleanliness and hygiene were in place. They commented they found the staff to have a good understanding of hygiene and infection control and promotion. Between the routine visits, of required staff were able to telephone the team at RUH for advice and/or guidance.
- The ward staff completed a weekly audit of the cleaning of commodes. Since January 2016 there had been 100% compliance with the exception of one week in February where a commode did not have a label attached to identify it had been cleaned.

- Staff on Violet Prince ward were responsible for carrying out hand hygiene audits. These were completed each month on the ward. We were provided with data for January and February 2016 which showed 100% compliance with the handwashing procedures.
- A weekly infection control audit took place regarding the care and treatment of patients who had a cannula inserted. For example, for the use of an intravenous drip. Staff were required to record the care and treatment provided and an audit was completed by reviewing records. We saw that Violet Prince ward scored 100% compliance on the audits completed in 2016.
- The ward was separated into bays with either two, four or six beds in a bay. The bed spaces were separated by curtains for privacy. The curtains were made out of material and required washing. Staff told us the curtains were washed routinely and when the bed space was deep cleaned. During our inspection we were not provided with a record to evidence how frequently the curtains were changed. However,information provided by the trust following the inspection informed us the curtains were routinely changed every three months and steam cleaned between the admission and discharge of patients and changed where necessary. A record was provided following the inspection which showed that the curtains had been changed every three months. Further records were provided entitled 'steam cleaning record for bins and toilet and ward'. These records showed that between May 2015 and February 2016 the steam cleaning had been carried out each month. However, there was a gap from the 25 February 2016 until the 7 July 2016 where the record did not show the steam cleaning had been carried out. The record did not specify that the curtains were steam cleaned or changed between the routine three monthly change.

Environment and equipment

- The wards and departments within the hospital had been reconfigured. However, not all signs had been moved and directed visitors to the hospital inappropriately. For example, physiotherapy and occupational therapy had moved but the signs remained at the previous site and the pain management team occupied space previously used by the head injury unit which had moved to RUH. The signs for the head injury department remained in place.
- The hospital was housed in a very old building which we were told was a listed building. This therefore had implications for updating and modernising the environment.
- Patients commented to us that the décor of the hospital had been improved and updated over the few months prior to our inspection.
- On the ward in a patient toilet, we observed the soap dispenser was located on a wall away from the sink and behind the toilet hand rail which meant it was difficult to access. For some patients it would not have been possible.
- Fire extinguishers were located throughout the ward and had been serviced within the last year. This demonstrated they had been checked to ensure they were functional and ready to use when required.
- There were portable oxygen cylinders located on the ward which could be transported where required. Portable suction units were also available and in a central location which staff were aware of. These were checked daily by staff to ensure they were fully charged and ready to use.
- Resuscitation equipment was available on the ward and daily checks were carried out by staff to ensure the equipment was present, correct and ready to use in an emergency situation. The medicine required for use in an emergency situation was stored in tamper evident bags so that staff would be able to quickly identify if any medicine had been removed from the bag. This reduced the risk of medicine not being available when required.
- A log was maintained of medical equipment in use on the ward, including the date of the last service and maintenance. A member of staff from the estates department was based at RNHRD and provided staff with assistance with ensuring the equipment was ready for use and available when required. The equipment used on the ward for care and treatment of patients was maintained by the trust estates department. Stickers were placed on the equipment to show when servicing and maintenance had been carried out. The equipment we saw was in date with the maintenance programme.
- The hospital gym and hydrotherapy pool was available for use by patients on the ward, as part of their care and treatment, subject to satisfactory risk assessments to ensure their safety. Appropriate checks were made on

the water in the pool twice a day to minimise the potential risk of infection to patients who used this facility. A log was maintained to identify the outcomes of the checks.
- The hospital had provided patients with a 'resource room' where they were able to use a computer, access the internet and charge their mobile telephones. Patients were able to use this facility alone or spend time with friends and relatives in this area.
- The ward had access to a large day room which was divided into seating and dining areas.
- A garden area with seating was available at the rear of the hospital. The design of the garden afforded patients privacy when using this facility.
- The hospital was secured at night by the porters to ensure the safety of patients and staff.

Medicines

- Patients were able, subject to satisfactory risk assessments and their agreement, to self-administer their medication. The medication was stored in lockable cupboards located near to the patient's bed with the key held by the patient. A spare key was stored securely by the staff in case of loss.
- Patients who could not self-administer their medication were supported by the staff. A signed medication administration record was completed to provide evidence on all medication taken by the patient.
- Each day a trained nurse signed a check list to identify that each medication administration record had been completed, either by the patient or by the nurse. This ensured that no medication had been missed in error. We reviewed medication administration records and risk assessments relating to self-medication for seven patients on the ward and found they had all been completed fully.
- Patients were encouraged to bring in their own medication for the duration of their stay. However, the RNHRD had access to pharmacy services each day from the RUH and additional medication could be obtained promptly when required.
- Medicines which required cool storage were stored in a refrigerator specifically for this purpose. The temperature was monitored each day by staff to ensure the medicines were kept at the correct temperature.
- Fluids for intravenous infusion were stored on the ward in a metal cupboard in the corridor. We saw the cupboard was left unlocked during our inspection. The cupboard was in an area accessible to patients and visitors to the ward which meant they could be accessed by unauthorised persons.
- A pharmacist attended RNHRD regularly to provide medicines support and guidance. Staff were positive about this support and commented they could contact the pharmacist by telephone in between visits for additional guidance, if required.
- Staff had electronic access to the trust policies and procedures regarding the safe ordering, storage, administration and disposal of medicines. Audits took place regarding the storage of medicines on the ward. This ensured the medicines were stored appropriately and securely.

Records

- There were no care plans in place to direct and inform staff on the care and treatment needs of patients. This was of particular concern when patients were transferred from RUH with complex needs. We identified there were incomplete care records for patients with identified complex medical needs and associated risks. We spoke with the charge nurse and hospital manager regarding these issues and were informed the paperwork should have been in place and completed. However this was not the case. Records did not provide clear evidence of the involvement of and referrals to other professionals. Risk assessments were incomplete for three patients. There did not appear to be systems in place to routinely review the care records and ensure appropriate documentation was completed and maintained appropriately.
- At the end of each bed was a folder which contained a patient assessment checklist and a number of risk assessments. The assessment checklist identified brief information relating to the patients' needs including mobility and transfer support, assistance required with meals and any issues with elimination (using their bowel and bladder). If necessary, a separate catheter care daily record chart was in place to show care provided to a patient who had a urinary catheter. A separate recording tool was in place to identify any support a patient required with position changes and wellbeing known as 'comfort rounding' together with, if necessary, a pressure ulcer prevention and

management plan. Food and fluid charts were maintained for some patients to monitor the amount of fluids and diet the patient had taken over a 24 hour period.

- We reviewed a number of fluid charts that were in use on the ward for specific patients. A fluid chart monitors the intake (drinks and intravenous or subcutaneous fluids taken in by a patient) and their urinary output. The fluid chart gave provision for the total input and output to be recorded at the end of a 24 hour period. We saw one patients fluid chart identified very low amounts had been taken in and excreted over a 24 hour period for three consecutive days. There was no recorded evidence of the action the staff had taken regarding this. On one day the fluid chart had not been totalled which may have indicated staff had not identified the significantly low intake and output of fluids. We spoke to the ward manager regarding this and they agreed this should have been escalated to the doctor but were unable to establish from the records if this had happened.
- Another patient also had a fluid chart which showed limited output on a number of days. This patient had a urinary catheter in place and a member of staff we discussed this with stated when the catheter had been emptied it had not been recorded. This was required to be done as concerns had been raised about the patient's fluid intake and/or output. Recording the fluid output for a patient can assist in monitoring the patient's hydration levels and kidney function.
- There was no completed risk assessment and/or care plan in place to guide and advise staff on how to meet the patients' needs in respect of their food and fluid care needs. This also meant that there was no plan or guidance in place regarding the action to take when concerns were identified.
- The care needs assessment checklist for another patient on the ward identified they required assistance and monitoring with their food and needed additional supplements to their diet. There was no further information regarding these issues and we did not see a care plan to direct and inform staff, or that a nutritional risk assessment had been completed to inform the nursing staff and other professionals.
- We reviewed the records for a patient on the ward who staff told us had complex medical needs as they were living with dementia and required a high level of nursing care. The care records did not indicate the person had dementia care needs. The electronic patient record system stated the patient did not have dementia. The handover sheet used by staff informed that the patient was confused and had dementia. There was no care plan in place to advise and guide staff regarding the patient's dementia care and treatment needs. The patient also had diabetes but there was no care and treatment plan, with the exception of the medicine administration record, on how to meet their diabetes care needs.
- A multidisciplinary folder was securely stored in the staff office in which all staff involved in the patients care recorded their notes including the medical staff, psychologists, nurses and therapists.
- A brief written summary was developed by the pain management team and provided to the nursing staff on the ward regarding the patient's needs. There were no care plans for patients who were admitted to the ward for a pain management programme. We spoke with a psychologist who was part of the pain management team. They told us this was because the care and treatment was based on a self-management programme and not a medical or nursing model of care. However, this did not ensure that nursing staff had full information regarding the planned care and treatment for each patient. For example, patients who stayed on the ward and not in self-contained flats and attended the programme daily did so because they required additional help. We were told often the patients had a carer at home and required assistance with their mobility or personal care. Their care records did not reflect the level of help they required.
- Information was shared on a daily basis in a written log from the psychologists and therapists on the pain management team and the ward staff. This enabled staff to understand any effects of the day's treatment that the patient may experience in the evening or overnight. For example, tiredness or showing signs of emotion.
- The rheumatology and medical patients did not have written care or treatment plans available.
- A handover sheet was provided to each nurse which included the name, date of birth and diagnosis of each patient plus any relevant information regarding the patients care and treatment. For example, blood tests required on that day.
- At the time of our inspection there were two systems of record keeping in operation as the RNHRD patient records were transferring to the RUH electronic patient

record system. This meant that staff who worked in the medical records department experienced delays in locating records as they could be stored under one or the other system. The resilience and commitment of staff was demonstrated as clinicians were very complimentary about how this had not impacted on the service provided. Clinicians told us patients admitted to the ward for rheumatology care and treatment or pain management programmes always had medical records available.

- The medical records containing patients private and confidential information were stored securely in the staff office which was opened with a key pad and remained locked during our inspection.
- We spoke with two registered nurses on the ward who acknowledged that there was an issue and need to update care plans and that the completion of documentation needed improving.

Safeguarding

- Staff had access to the trust policy and procedures regarding safeguarding adults and children. They were required to complete safeguarding training as part of their mandatory training. Data we received from the trust showed that 89% of required ward based staff had completed level 2 safeguarding training. Following the inspection the trust provided information which stated 81% of medical staff had completed level 2 safeguarding training.
- Information displayed on the ward provided guidance and prompts for staff regarding domestic violence and the action they were required to take should they suspect this affected any of their patients. Staff we spoke with were knowledgeable about the process and were confident patients would be supported appropriately.
- Information was displayed on the ward regarding the safeguarding and protection of children and adults teams, who could be contacted to provide advice, guidance and support. Staff knew where to access the policy and procedure regarding the safeguarding of adults on the trust intranet.
- We read the multidisciplinary notes for one patient. We saw that staff had observed old and new bruising to their hands and wrists. Whilst detail was recorded on the observation it was not clear what action had been taken in response to the identified safeguarding concern. We spoke with a senior nurse on the ward who was unclear of the action taken. Seven days later further concerns were raised and recorded regarding bruises on the patient and a comment made that the concerns were to be discussed with the safeguarding adults lead for the hospital. A record made later that day informed that a safeguarding referral had been made on the trust electronic system and then cancelled. The reason for the cancellation was illegible to us and to staff on the ward. A senior nurse on the ward did not know who had made the entry in the notes so was unable to follow this up immediately. We received assurances that the concerns would be investigated. This did not ensure that staff were aware of the correct policies, procedures and systems to be followed when they identified a safeguarding concern.
- Guidance to the action staff were required to take should they suspect domestic violence and abuse was displayed in the staff office on the ward.

Mandatory training

- The electronic training records identified that the mandatory training consisted of the following:
  - Blood Transfusion Processes,
  - Conflict Resolution,
  - Equality and Diversity,
  - Fire,
  - Health and Safety,
  - Corporate Induction,
  - Local Induction,
  - Infection Prevention and Control,
  - Information Governance,
  - Mental Capacity Act and Deprivation of Liberties,
  - Moving and Handling,
  - Resuscitation,
  - and Safeguarding.
- There were discrepancies in the recording of staff training in that not all of the records reflected all of the training completed by staff.
- The January 2016 performance indicators that were displayed on the ward showed 87% of mandatory training had been completed by staff. However, training records showed not all staff were up to date with the mandatory training programme. For example, only 50% of the medical staff and 47% of the bank staff had completed Mental Capacity Act 2005 training, and only 62% of the bank staff had completed moving and handling training. This meant that a large number of staff and subsequent patients were at risk from not

having up to date training and skills when moving and handling patients or stationary loads. The bank staff who worked at RNHRD were not up to date with other mandatory training such as resuscitation, safeguarding adults and children and infection control and prevention. Five of the registered nurses on the ward were not up to date with their fire training. This was a concern as all staff rotated to night duty and potentially would need to take the lead should a fire occur at night. The trust advised us that fire training had been booked for these staff.

- Staff we spoke with were confident they were up to date with their mandatory training. They were made aware of when their training was due as the electronic system sent a reminder email to both the member of staff and their line manager. This enabled managers to monitor the training for staff. The managers we spoke with commented that the electronic system did not always accurately reflect the training which had been completed by staff. We were shown examples of where the system showed a member of staff was out of date for specific training but the manager was able to evidence that the training had been recently updated and completed.
- The managers followed up these issues when identified with the training department who held responsibility for updating the electronic training logs.

Assessing and responding to patient risk

- A nationally recognised early warning system (NEWS) was in place to identify when the medical condition of patients was deteriorating. The charts informed staff of the action to take when the patients physiological measurements such as pulse, temperature or blood pressure, gave cause for concern. We saw that one patient had a recorded score which indicated the measurements should be rechecked within a short of period of time. According to the record this had not been carried out until the next day. Another early warning score record for a separate patient identified medical attention should have been sought. However there was no record which showed this had been done or that any action had been taken in response to the concerning physiological measurements recorded.
- Patients whose medical condition deteriorated were seen initially by the doctors at the Royal National Hospital for Rheumatic Diseases (RNHRD) but if they required acute treatment the medical team liaised with their medical colleagues at the Royal United Hospital (RUH) and arranged for the patient to be transferred and admitted to the RUH.
- Information provided on the ward safety dashboard showed that when audited, the completion of NEWS recording was at 93% when reviewing the figures from April 2015 to February 2016.

Nursing staffing

- Staff working on Violet Prince Ward received a full and detailed handover at the start of their shift from the nurse who had worked the previous shift. We attended a handover between the night staff to the day staff. We saw each patient was discussed and their health and wellbeing commented upon.
- Staff commented on the changing patient group and the associated care needs of the patients admitted to RNHRD and how this impacted on staffing levels. There had been concerns that while the numbers of patients with complex care needs being admitted to the ward had risen, initially the staffing levels had not. Staff were able to describe how the skill mix of staff had changed to include additional health care support workers on the duty rota to help resolve these concerns.
- The safer staffing tool was used and the results from this audit identified increased staffing numbers and the skill mix of staff had changed to meet the care needs of patients with increased acuity (level of need). This had taken place following an increased admission of patients with complex medical needs from the RUH over the last year.
- Staff confirmed that should a patient have increased needs, additional staff could be placed on duty with the agreement of the hospital manager or in their absence the senior nurse on the ward. The additional support was obtained by permanent staff temporarily increasing their hours or from bank staff. No agency staff had been used.
- Records showed that in September 2015 there had been five members of staff on long term sick leave. This had since reduced and at the time of the inspection staff commented that sick leave did not affect the daily running of the ward. Minutes of the staff meeting from February 2016 showed that there had been no concerns regarding the numbers of staff on sick leave.

Medical staffing

Medical care (including older people's care)

- There was a consultant rheumatologist on call at all times. During the day doctors such as registrars and senior house officers were available for the care and treatment of the rheumatology patients on the ward. A rota was in use to show which doctor was on duty and providing an on call service during the evening, at night and over the weekend.
- The doctors also provided medical support to the pain management programme patients and medical patients who had been transferred from RUH.
- There was no clear structure in place for the provision of medical cover to patients who had been transferred from the RUH to the RNHRD. We spoke with the head of division for medicine at the RUH who had responsibility for the care and treatment of patients at the RNHRD. Consideration was being given to a consultant geriatrician or specialist registrar geriatrician visiting all patients at the RNHRD at least once a week to support the resident medical officers. This had yet to be formalised.
- During the inspection, we had concerns about the arrangements in place regarding the medical (doctor/consultant) cover for medical patients who had been transferred from the RUH. We were told the day to day medical care was provided by the senior house officers and registrars who worked at the RNHRD providing care and treatment to the rheumatology patients. A named consultant telephoned the RNHRD each week to offer advice and receive an update on the wellbeing of these patients. The junior doctors at RNHRD were able to telephone this consultant during the week if they required assistance. The junior doctors provided on call support to nursing staff during the evenings and weekends, in response to any concerns regarding the health, care and treatment for patients on the ward at RNHRD. One junior doctor expressed concerns regarding the level of responsibility bestowed upon them when caring for patients who had been transferred from medical wards at RUH with complex needs.
- The medical staff did not have a formal handover each day. However, we observed two doctors discussing the treatment and care needs of one patient.

Major incident awareness and training

- Emergency evacuation equipment was located on the ward, in the corridor and in the bay. Staff received training on how to use the equipment during the annual fire drill. Two members of staff we spoke with on the ward were unclear of what the equipment was as it was stored under a cover that was not labelled.

Are medical care services effective?

Good

We judged medical services as good for effective because:

- Staff provided care and treatment in line with the trusts policies and procedures and national guidelines. When national guidelines were amended the staff reviewed their care and practice against the new guidelines.
- Patients were offered support with their meals and additional snacks and drinks were available to patients at all times.
- Staff were encouraged and enabled to attend training and conferences regarding specialist care and treatment needs with which patients presented.
- Multidisciplinary team working was effective and at times outstanding at the hospital.
- The medical records department was based in the hospital and provided an effective service to clinicians.

However:

- Not all services were operational over seven days. Patients did not have routine access to therapy, x-ray and medical staff out of hours or at the weekends. During our inspection we were told consideration was being given to a consultant geriatrician or specialist registrar geriatrician visiting all patients at the RNHRD at least once a week to support the resident medical officers.
- Not all staff demonstrated a clear understanding of the Deprivation of Liberty Safeguards.

Evidence-based care and treatment

- Staff we spoke with were aware of the policies and procedures which provided them guidance and information when delivering care and treatment to patients. The policies and procedures were in line with national guidelines such as those made by the National Institute for Clinical Excellence (NICE). NICE provide national guidance and advice to improve health and social care.

Medical care (including older people's care)

- We saw evidence that NICE guidelines were referenced in divisional and governance meeting minutes. Staff told us this was to ensure that current practice at the hospital was in line with national guidance. When guidelines changed, discussions took place at the divisional and governance meetings to decide how the changes affected practice.
- Staff referred to the National Society of Rheumatoid Arthritis guidelines. A number of staff were members of the society and were provided with regular updates in national guidelines from the society.
- A local audit of the standard of the completion of patient's medical records had taken place. We found the most recent audit had made some recommendations regarding the need for the patient identifiers and the consultants name to be identifiable on each page.
- An audit had been carried out in February 2015 reviewing the number of preventable admissions to rheumatology. Recommendations had been implemented following the audit. These included specific yellow coloured forms to be filed in notes when an admission had been arranged to ensure the information was clearly identifiable, and clear goal setting addressed at the assessment/ consultation meeting.

Pain relief

- Patients were admitted to the ward to enable them to take part in the pain management programmes run at the RNHRD for people who experienced complex and chronic pain. Discussions were carried out between staff and the patients regarding their required pain relief and we observed staff were empathetic and supportive when patients experienced pain. Pain relief was provided promptly when necessary.
- At each nursing handover information was shared between staff identifying when patients had last had pain relief.

Nutrition and hydration

- The Patient Led Assessments of the Care Environment (PLACE) scores for 2015 showed the RNHRD scored 59% for the standard relating to the organisation of food, this was lower than the national average of 87%. The outcomes for standards relating to food, hydration and ward food sampling were similar to the national average. The assessments are completed by teams of local people who review how the care environment supported patients.
- Protected meal times were in place on the ward. This means that during the course of the meal time visitors and clinicians do not interrupt the meal enabling the patient time to eat their meal whilst it was hot without distraction.
- Staff and patients told us that whilst they considered the food to be good, the quality was not as high as previously. One patient told us there was less choice when compared to previous admissions. A volunteer told us that patients consistently told them the food was not as good as it used to be. Patients we spoke with were positive about the food provided and said it was tasty and served at a hot temperature.
- Patients were able to make choices about their menus. We saw staff asked patients what they would like to eat the next day. We observed a menu sheet which offered patients a choice of two hot meals, one of which was vegetarian, salads and sandwiches at midday. The evening meal was lighter and offered a variety of sandwiches, pastries and soup and roll. There was a choice of desserts for each meal.
- Staff on the ward told us that the catering staff were obliging, helpful and strived to ensure patients had food which they liked and wanted to eat. On occasions this had meant providing food which had not been on the menu.
- The patients on the ward had access to a dining area from where their meals were served. All patients were encouraged to attend this area for their meals. For patients who were unable to access the dining room, for example due to their physical or mental health, meals were served at their bedside.
- Fresh fruit and drinks such as tea, coffee and squash were available at all times in the dining room.
- A café/restaurant was available in the hospital for staff, patients and visitors to use. A wide range of meals and snacks were cooked and prepared on site and available between 12pm and 1.30pm.
- A dietician visited the hospital each week to provide guidance and support for patients. We did not see any records in patient notes made by the dietician.
- Monitoring charts were in place for a number of patients for whom there were concerns regarding their food and fluid intake and/or output. The charts were not in

sufficient detail to identify the food intake for three patients whose notes we reviewed. For example, comments such as 'ate half' were used but this did not specify half of what. Where patients had clearly not eaten for a period of time or only had sips to drink there was no clear documented evidence to show what action had been taken. We asked staff on the ward to identify what action had been taken and they were unable to tell us.

- One patient experienced difficulties swallowing. The nursing records recorded that they required a full assessment by the speech and language therapist (SALT). There did not appear to be a process to follow this referral up and staff we spoke with were not clear whether a SALT assessment had been undertaken. We reviewed the patient's multidisciplinary team records and could not see that at the time of our inspection (26 days after it had been recorded that the SALT assessment was required) that any further entries had been made regarding the assessment. It was also unclear whether the person was provided with a pureed, soft or normal diet. Comments made in nursing notes and on the food chart showed the diet varied which put the patient at risk of choking if they did require a pureed diet.
- We reviewed the records of one patient regarding their diet and nutrition. There was no specific care plan in place for this patient and no clear plan as to whether they required a pureed, soft or normal diet. Written records identified that the diet provided varied between the three. This potential caused a risk of choking if the patient did in fact need a pureed diet.

Patient outcomes

- Auditing of patient journeys showed that 1.6% of patients would be readmitted to the ward after discharge. The trust monitored the average length of stay for patients, which for Violet Prince ward was 8.6 days.
- The hospital had been awarded as a centre of excellence for lupus. This was based on criteria assessed by the national lupus organisation which the hospital had to meet. The criteria included, number of consultants with lupus specialist knowledge, the appointments system, quality of explanations to patients, the information given to patients regarding the side effects of investigations and the availability of dedicated nurse specialists.
- The occupational therapists were participating in the national osteoarthritis of the thumb therapy trial. They were experiencing positive results for patients.

Competent staff

- The January 2016 performance indicators displayed on the ward showed 83% of the staff appraisals had been completed. Staff received an annual appraisal where they met with their line manager and discussed their work and plans for the coming year. Data showed staff were up to date with their appraisals and this was confirmed by the staff.
- During our inspection we attended a multi-disciplinary team meeting held by the pain services. We observed a high level of clinical knowledge and expertise was shared between professionals attending the meeting. The staff were active in teaching external professionals at local, regional, national and international venues and conferences due to the high regard in which the team were held for their work at the RNHRD.
- Patients could attend the RNHRD either as inpatients or staying nearby in self-contained flats, dependent on their care needs and independent living skills. The patients who stayed on the ward were provided with care from the nursing staff. The psychologists who led the pain management programmes and a nurse provided nursing staff with informal training regarding the philosophy of the programme and how to support patients with their treatment.
- Two nurses working at the RNHRD were due to revalidate their nursing registration with the Nursing and Midwifery Council (NMC). The trust had appointed a lead nurse to support staff with the new scheme of revalidation for nurses. Training had been provided by the lead nurse and also the union representative. The hospital manager had spoken with trained nurses to ensure they were confident with the process of revalidation. Two nurses we spoke with confirmed they had been well informed by the trust about the revalidation.
- The trainee doctors at RNHRD were supplied through the local NHS Deanery. An NHS Deanery is a regional organisation responsible for postgraduate medical and dental training, within the structure of the National Health Service (NHS). A consultant at the hospital provided support to the trainee doctors both at the

hospital and the Deanery. Junior doctors we spoke with were positive about working at RNHRD regarding the experience and training opportunities they were provided with.
- Concerns were expressed by both nursing and medical staff regarding the care and treatment needs of patients transferred to the RNHRD from the RUH with complex medical conditions.

Multidisciplinary working

- The culture at the hospital enabled every member of staff we spoke with to feel part of the multidisciplinary team. All staff commented that they were able to speak with any other member of staff irrelevant of their role regarding the care and treatment of patients at the hospital.
- The complex regional pain syndrome (CRPS) service held a weekly multidisciplinary meeting. We attended this meeting during our inspection and found the content and style of the meeting to be outstanding. Internal and external professionals attended the meeting including: the clinical psychologist, occupational therapist, physiotherapist, Macmillan nurse, nurse specialist for pain services, research nurse, the ward charge nurse and the consultant. Links with other professionals were made and feedback from them was discussed at the meeting if they were not able to attend. For example GPs, adult social care services and therapists from the community both locally and nationally.
- The CRPS followed a holistic multidisciplinary working model which was based on patient goals and expectations. Options for the patients discharge and support post discharge was discussed at length both within the meeting and with the patient.
- The staff at the RNHRD worked well with external organisations for example, when carrying out research on projects led by external organisations.
- We saw clear evidence of excellent liaison and feedback with GPs both while the patient was on the ward and following discharge. One such example was the communication with a patient's GP after they expressed thoughts of self-harm.
- The self-management pain groups were run at the hospital by a multidisciplinary team of staff including psychologists. We observed a psychologist providing advice and guidance to a concerned staff member regarding the mental health of another patient on the ward.
- A system had been introduced whereby a senior nurse attended the RUH on a weekly basis, to liaise with staff and assess patients deemed as appropriate for transfer to the RNHRD.

Seven-day services

- The ward was open seven days a week for the full 24 hour period.
- Medical staff and consultants were on duty during the day Mondays to Fridays and saw each patient admitted under their care on a daily basis. The junior doctors were on-call at the weekends and out of hours should patients require medical assistance.
- The consultant and doctors operated an on-call system during the evenings, nights and weekends. Staff reported this service was efficient and responsive to their needs.
- The trust informed us that the medical care and treatment of patients who had been transferred from the RUH to the RNHRD was the responsibility of the head of divisions for medicine. When this person was absent geriatricians from the RUH covered this role on a rotating basis. During our inspection we were told consideration was being given to a consultant geriatrician or specialist registrar geriatrician visiting all patients at the RNHRD at least once a week to support the resident medical officers.
- The x-ray department was closed during the evenings and at the weekends. If a patient required an investigative x-ray during these times they were transferred to the RUH.
- The pain management and chronic fatigue services provided programmes of varying lengths. The team consisting of occupational therapists, physiotherapists, consultants and psychologists did not work at the weekends. This was planned to provide patients with a break during their intense programmes. Often patients went home for weekend leave but if they remained on the ward any required care and treatment was provided by the nursing staff.
- There was no access to therapy staff at the weekends aside from the emergency cover supplied by the RUH team. If a patient required this service they would be transferred by ambulance to the RUH.

Medical care (including older people's care)

Access to information

- Patients were admitted to the Violet Prince Ward for care and treatment regarding their pain management. Detailed information regarding the patients' needs was obtained prior to admission from the referring professionals, initial assessments and two further meetings with the patient and the pain team. Information was provided to the nursing staff verbally in a weekly handover which took place prior to the patient being admitted. A written summary sheet which contained details of all of the patients due to be admitted was provided at this meeting to the ward staff. We were told this information was transferred onto ward documentation and then shredded. We did not see evidence on the ward of the information sheet.
- A brief written summary was provided to the nursing staff regarding the patients' needs which was filed in the multidisciplinary notes folder for each patient.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in hospital are looked after in a way which does not inappropriately restrict their freedom.
- Staff had access to the trust electronic policy and procedure regarding DoLS. Any deprivation of liberty to protect or care for the vulnerable patient would be in their best interests. A vulnerable patient would be one who did not have the mental capacity at the time to make his or her own decisions. The trust policy stated an authorisation would not be considered if the patient's stay was not likely to be more than 72 hours, but it did not provide for flexibility in relation to the application of the 72-hour rule. The policy also did not yet reference the 2015 guidance from The Law Society for deprivation of liberty in hospital settings.
- Further information was displayed in the staff office on the process staff would follow regarding any potential DoLS.
- A number of staff, including medical staff, we spoke with did not appear to have a good understanding of the process and legislation. One junior doctor was not aware of the trust training regarding DoLS and believed that any DoLS application would be carried out at RUH before patients were transferred to the ward.
- We reviewed the records for a number of patients on the ward. One patient living with dementia's daily records showed on one occasion they had wished to leave the ward and requested that the police be called when they were unable to leave. However, there was no record made regarding the consideration given to making a DoLS application.
- The trust had an up to date policy and procedure in place relating to consent to care and treatment. The policy and procedure informed staff that valid consent had to be obtained before treatment or examination.
- We observed patients were given information prior to tests and treatment being provided. For example, before blood was taken. Patients gave their verbal consent to staff.

Are medical care services caring?

Good

We judged the medical service as good for caring because:

- Feedback from patients and/or their representatives was consistently positive about the manner in which staff treated them.
- We observed staff were kind, compassionate and showed empathy to those they cared for and provided a service to.
- Patients were provided with sufficient information and support to help them understand their care and treatment plans and options available to them.

Compassionate care

- We spoke with two patients who had been admitted to the ward while completing the complex regional pain syndrome (CRPS) programme. They both said they had been treated kindly and with dignity and felt well cared for. One patient had experienced several stays at the hospital and said they had always been provided with good care and attention.
- We also spoke with three patients who were admitted to the ward for care and treatment for their rheumatology condition. The patients had attended the hospital on several occasions and said the staff were helpful, kind

and caring. Specific comments included "they [the staff] go above and beyond the call of duty" and "they [the staff] are always prepared to respond to requests for help and deliver more than just the basics."

- The hospital participated in the NHS Friends and Family Test (FFT) which helped service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. The results received from patients at the RNHRD, whilst not always a high response rate, were positive. In November 2015, 35% of patients responded with 95% of those recommending the RNHRD. In December 2015, 34% of patients responded with 94% recommending the hospital, and in January 2016, 38% responded with 90% stating they would recommend the hospital.
- The trust carried out a survey of patient satisfaction. At the RNHRD a hospital volunteer talked to patients and put their responses into the trust database. The volunteer told us the responses were generally very good, although increasingly patients were not as satisfied with food. Another issue that had arisen on the ward was regarding the noise at night due to admissions and other patient needs. The staff tried to reduce the impact on patients by locating the patients on the pain management programmes together at one end of the ward. They also utilised side rooms where possible for patients who were likely to be awake at night.

Understanding and involvement of patients and those close to

- We spoke with patients on the ward to seek their view on how they were involved in and understood their care and treatment plans. Patients were positive regarding the staff. One person said "they [the staff] are proactive to involve me in all decisions, explaining everything well so I can make proper decisions."
- We observed one member of staff spending time with a patient ensuring they were informed about their condition and the recommended care and treatment.
- Information leaflets were available on the ward about specific conditions and diseases and we saw one member of staff reading the leaflet with a patient and highlighting important aspects.
- The medical records for one patient had an entry which identified the clinician had spent time with the patient discussing their new diagnosis and prognosis.
- The hospital was a recognised Lupus centre of excellence. Part of the criteria to achieve this award was the quality of explanation to patients and that patients were informed of the side effects of investigations.

Emotional support

- Patients told us should they have any concerns regarding their care and treatment, they were able to contact the consultant between appointments via the secretary. They commented this was helpful and reassuring.
- Clinical nurse specialists were available to support patients and staff in the management and control of their conditions. The clinical nurse specialists provided patients with verbal advice and support by telephone between appointments.
- Psychologists provided emotional and clinical support to patients attending the outpatients department when required and as part of the self-management programmes in place.
- The hospital was a recognised Lupus centre of excellence. Part of the criteria to achieve this award was the availability of a dedicated specialist nurse and a helpline for support between admissions.

Are medical care services responsive?

Requires improvement

We judged medical services as requires improvement for being responsive because:

- At times the medical patients transferred from the Royal United Hospital (RUH) did not always meet the criteria in place and at times, their care needs were complex and impacted upon patients already on the ward. There was limited therapy support for these patients.
- The ward did not fully meet the care needs for patients living with dementia. Whilst the admission criteria was clear that patients living with dementia should not be transferred to the hospital, there were patients transferred to the RNHRD living with dementia.

However:

- Patients were provided with appointment dates promptly when assessed as requiring admission to the ward to take part in a pain management programme.

- Senior staff from the ward visited RUH on a weekly basis to carry out an assessment on patients who were considered medically fit to transfer to RNHRD
- The hospital listened to patients who had a complaint and action was taken when a complaint was made.

Service planning and delivery to meet the needs of local people

- Staff and patients expressed concern regarding the planned move of the services from the RNHRD to the RUH. The trust informed us they were undertaking a phased programme of targeted Public and Patient Engagement (PPE) regarding proposals to relocate services from the RNHRD. Internal communications and engagement were also being planned.
- Patients commented on the usage of the hospital for medical patients transferred from RUH and how the care and treatment of acute medical patients impacted on the rehabilitation care and treatment.

Access and flow

- The access and flow of patients into the RNHRD had been affected since the hospital had been acquired by the RUH trust. Action had been taken to address this.
- During a meeting with the clinical leads and senior management for the RNHRD, we were told there was a strict admission and transfer from RUH criteria for patients coming into the RNHRD. They added this did not include patients living with dementia as the environment was unsuitable.
- The hospital had been acquired by the acute trust in February 2015. Prior to this, patients were admitted to the hospital for the management and control of complex pain and the treatment and care related to rheumatology conditions and diseases. Since February 2015 staff described the admission of patients who had been transferred from the RUH with ongoing medical care and treatment needs. At times their conditions were complex. Staff told us the ward had a budget in place to fund 16 beds. At the time of our inspection 22 beds were open to enable medical patients from the RUH to be transferred as a result of trust wide bed pressures.
- Criteria had been developed for staff at the RUH to refer to when planning to transfer patients to RNHRD. This clearly outlined the process which was to be followed and the complexities of care and treatment that could be provided at the RNHRD. Recommendations were included regarding the time patients could be transferred so that they did not experience undue distress or disturbed nights due to moving hospitals. Admitting patients at night had previously impacted on patients who attended the pain management programme. This was because the programme was intense and the lack of sleep patients had suffered impacted on their progress with the programme the following day.
- During our inspection there were five patients on Violet Prince ward who had been transferred from the RUH due to pressures on medical beds at the hospital. All five patients were waiting for arrangements to be made for community health or social care before they could be discharged. Two of the patients had complex/multiple health and/or medical care and treatment needs, and were living with dementia. Staff expressed concerns that when there was pressure on the medical beds at the RUH the criteria for admission to the RNHRD was often over-ruled and patients were admitted to RNHRD.
- We saw that patients had been transferred late at night from the RUH. For example, one patient arrived at 2.30am and another at midnight. This did not comply with the transfer policy or guidelines. A senior nurse from the ward visited the medical wards at the RUH to assess patients deemed as medically fit and able to be transferred to the RNHRD. The intention was for this to reduce the number of patients with complex care needs being transferred to the RNHRD. Staff commented this had been effective. However, when pressures were experienced at the RUH which required additional medical beds, the RNHRD received medical patients to free beds at the RUH. Staff stated at these times the patients may not have been visited by the senior nurse to assess whether their care needs could be met at the RNHRD.
- The senior administrator for the pain team and the ward clerk met weekly to plan ahead the patients booked to come into hospital for the pain management programmes. Regular communication took place with the site manager at the RUH to inform them of any bed availability which would enable patients to be transferred and thus freeing up beds at RUH.
- The trust did not consider these patients transferred to be medical outliers (medical patients who were admitted to other specialities due to a lack of medical beds), as the RNHRD was considered to be part of the medical division. The ward clerk attended the morning

handover between the nursing staff and a review was held of the availability of beds and any patients who were due to be discharged. This enabled the ward clerk to plan future admissions and liaise with the acute hospital regarding medical patients who could be transferred to the RNHRD.

- A weekly meeting was held between the ward clerk and the senior administrators for the complex regional syndrome pain service, breast radiotherapy injury rehabilitation service and the Bath Centre for Pain Services. The meeting followed a set agenda the purpose of which was to review the future availability of beds in order to provide patients with dates of planned admission to the hospital for their treatment programme. Patients were initially seen in one or more outpatient clinics, the purpose of which was to assess their suitability to attend a programme. Once they had completed all their pre-treatment assessments the consultants added their name to a spreadsheet which was reviewed at this bed meeting. Records showed there were no patients on a waiting list to attend a programme. However, some patients had been provided with a date to attend a programme eight weeks in advance.
- A multidisciplinary team meeting was held to discuss the priority of patients who required a place on a programme. The places were offered accordingly.
- We were told by the administrators that on two occasions in 2016, medical patients who had been transferred from the RUH had not been discharged in time to enable planned pain management programme patients to be admitted to the ward. The staff had carried out further assessments and patients had stayed independently in the flat until such time as bed available on the ward when they were admitted.
- On occasions patients had cancelled their admission for a variety of reasons. Administrative staff liaised with the consultant and then attempted to provide places to patients booked in at a later date. This was not always easy as patients came from long distances and were not always able to arrange their personal circumstances at short notice.

Meeting people's individual needs

- The pain management programmes, chronic fatigue programmes and rheumatology care for patients at the RNHRD provided invidualised and personalised care for patients.
- There was information displayed on the ward for patients, their representatives and staff regarding the trust specialist dementia care team. This team were based in the Royal United Hospital (RUH). Staff were aware of how to access support from the team but those we spoke with told us they had not previously needed to access this service. Staff were not clear in their conversations when they would request support from the specialist team, yet recognised they had faced challenges with providing care and treatment to patients living with dementia. Further information was available for carers and those living with dementia regarding local groups and support. A pocket sized leaflet was available on the wards entitled 'How to help patients with dementia'. This leaflet provided practical tips and guidance for staff when caring for patients living with dementia.
- The environment was not set up to support people living with dementia. The ward was all painted the same colour and there were no visual prompts to individualise beds or bays. The toilets and bathrooms were clearly signed to show where these were although the doors and door frames were painted the same colour as the walls. This could be confusing and bewildering for someone with memory impairment.
- There was a dining room and small lounge area with a television outside of the end of the ward. Patients could relax in this space and there were a small number of magazines and books. However, as this was located off the ward, patients were required to be independent to use this alone and staff would be required to accompany a patient with additional needs. Staff told us additional staff were rostered on duty to support patients with additional needs, for example patients living with dementia or learning difficulties.
- At the time of our inspection there were three patients on the ward who were living with dementia.
- The Patient Led Assessments of the Care Environment (PLACE) scores for 2015 showed the RNHRD scored 55% against the dementia friendly standards which was worse than the national England average of 75%. The assessments are completed by teams of local people who review how the care environment supports patients.
- Patients could be admitted to the hospital for periods of between five and twelve days to follow specific pain management programmes. Concerns were raised by staff and patients regarding the impact some patients

who had transferred from the RUH had on their stay. The examples given included patients being transferred to the ward late at night or living with dementia keeping them awake. This had an ongoing effect on their ability to focus and get the best out of the programme.

- Information was displayed on the ward regarding the trust wide learning disability specialist nurses who provided support and guidance to patients and for staff who cared for patients living with a learning disability. Staff we spoke with were aware of this service but had not accessed it for support regarding patients at the RNHRD.
- There were limited opportunities for the medical patients to be provided with care and treatment by the physiotherapists or the occupational therapists. We were told this was because they were fully occupied with the patients attending the hospital for the planned pain management courses and the rheumatology patients. This meant that older people who required rehabilitation to enable them to leave the hospital were not provided with this treatment.
- Information leaflets were available on the ward to inform patients about conditions and diseases which affected them. The trust website was a useful resource for further information.
- Disability access to the hospital was good with lift facilities to access different floors. There were toilets that were accessible to people in wheelchairs and with other mobility aids
- The hospital had been accredited with the Lupus centre of excellence award. Part of the criteria for achieving this had been to provide an open door appointments system. This meant that the patients had a named contact to seek advice from between their regular appointments.
- Staff had access to a language line and interpretation services for patients whose first language was not English. They commented that these services were rarely used for their patient group.

Learning from complaints and concerns

- Patients and visitors to the hospital were advised on how to make a complaint and the contact details for the Patient Advice and Liaison Service (PALS) were displayed clearly. PALS offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and carers.
- Further information was displayed on the ward in a leaflet entitled 'giving feedback and making a complaint'.
- None of the patients we spoke with had made, or intended to make a complaint.
- There had been two complaints made during August and September 2015 regarding the attitude of one member of staff. There had also been an earlier complaint regarding the attitude of a staff member in March 2014 prior to the acquisition of the hospital by RUH. Whilst patients had received a response to their complaint, no formal action had been taken to address the complaints, to reduce the risk of reoccurrence at the time of our inspection. We requested an update on the action taken.
- The January 2016 performance indicators displayed on the ward showed there had been no complaints received.

Are medical care services well-led?

Requires improvement

We judged well led as requiring improvement. This was because:

- The trust had acquired the Royal National Hospital for Rheumatic Diseases (RNHRD) in February 2015. Governance systems had been put in place and in some areas were working well, in others they had not fully embedded.
- There was limited monitoring and quality measurement of the care and treatment records maintained for patients on the ward.
- There were significant gaps in the care records which had not been identified or addressed.
- It was not clear that feedback from patients had been actioned or that information was provided to staff regarding such actions. For example, patients had requested cooked food at breakfast times but staff were not aware whether there were any plans to address this.

However:

- There was a positive culture at the hospital and staff were proud of the service they delivered to patients
- There was clear local leadership in the hospital and staff were confident and able to approach the hospital manager for support and guidance when necessary.

- Not all staff saw their line manager regularly and sought support from other managers on site when needed.
- Staff meetings were held regularly to enable information to be shared and staff to be updated.

Vision and strategy for this service

- The RNHRD had been acquired by the Royal United Hospitals Bath Foundation Trust in February 2015. The vision and strategy for the RNHRD was to move the services provided to the RUH site.
- Meetings and consultation had taken place with staff and members of the public regarding the proposed move and the opportunity had been available for people to give their views on the proposed move.
- The trust informed us that a process of planning was taking place at the time of our inspection to make sure that all services will be transposed into a suitable environment at the RUH. This included work to ensure that integration with the acute services would be managed appropriately in order to meet the needs of a primarily rehabilitation service.

Governance, risk management and quality measurement

- There had been a governance pathway identified within the trust when the RNHRD was acquired. This was to enable the trust board to be made aware of pertinent issues from the RNHRD. The speciality governance meetings were held monthly and any issues were reported at the divisional governance meeting where they were reviewed and either addressed or escalated. If escalated, consideration would be given at the operational governance meeting whose members if necessary, could escalate concerns to the management board of the trust. The management board was attended by the executives and senior managers. Information from this meeting was provided at the trust board meetings.
- The rheumatology service at the Royal National Hospital for Rheumatic Diseases (RNHRD) reported within the trust medical division and pain services within the surgical division. The divisional managers for the medical and surgical divisions were based at the Royal United Hospital (RUH) and had responsibility for the oversight of governance at RNHRD.
- The divisional managers for medicine and surgery had been involved in the period of transitional change following RNHRD being acquired by the main trust. Changes in working practices had taken place to integrate the RNHRD into trust systems and processes and to monitor the quality and safety of the service provided to the patients.
- The hospital manager had responsibility for monitoring and updating the local risk register and provided information to the appropriate divisions regarding identified risks. The risks were presented at the three monthly divisional meetings and escalated when necessary to the trust wide risk register.
- We saw evidence that action had been taken in some areas where risks had been identified. For example, metal gates had been fitted to the previously open stairwell outside of the ward area. This was due to the risk of injury to inpatients at risk from leaving the ward unaccompanied and falling on the stairs. For example, those patients living with dementia.
- It was not clear that the governance pathways of risk management were embedded since the RNHRD had been acquired by the RUH. We spoke with senior staff and reviewed staff and divisional meeting minutes. There was not always clear evidence that risks had been reported and escalated and appropriate action taken in a timely manner.
- The risk register showed a number of historical risks which we were told had been closed but not removed from the register. The hospital manager was not aware of the process or system in place to close the risk and did not attend the risk meetings. The on site manager was involved with the risk management but not engaged in the meetings at a divisional level.
- The hospital manager viewed the electronic incident reports made by staff and escalated specific concerns within the appropriate division. The medical divisional manager was aware of issues affecting the RNHRD such as late evening or night transfers of patients and transferring of patients living with dementia. What was not as clear was the governance pathways in place to ensure action was taken to reduce the risk from these incidents.
- Staffing levels were reported on the trust electronic system when shifts were not filled. This information was flagged to senior managers both at the RNHRD and RUH. Staff on the ward made positive comments about the management support they had received in the past when requiring extra staff on duty. For example, to provide one-to-one care and support to a patient with complex care needs.

- We spoke with the named clinician who had the responsibility for clinical governance lead at the RNHRD. They considered that the governance systems were good. The clinician advised they reviewed clinical incidents which had been reported on the trust electronic system. The incidents were reported, if necessary, to the divisional governance meetings together with any necessary investigations. Reports were prepared for the monthly divisional governance meetings regarding the venous thrombus assessment (VTE) assessments, root cause analysis investigations of incidents; outcomes from audits and morbidity information.
- There appeared to be a lack of understanding regarding the management of patient records on the ward. We were not able to identify how quality monitoring of records took place to ensure the care and treatment needs of patients were being delivered. There did not appear to be systems in place to routinely review the care records and ensure such documentation was completed and maintained appropriately. This did not provide assurances that the leadership and management team were aware of the issues relating to care, treatment and risk assessment planning highlighted in the safety domain of this report.
- The hospital manger attended various management meetings such as the trust wide matrons meeting, infection control committee, medicines devices meeting and patient safety meeting to obtain and share information.
- Whilst patients were listened to when they raised a concern or complaint and received a response from the hospital, it was not clear that concerns were consistently investigated and/or addressed fully. This did not ensure action was taken to reduce the risk of the same complaint reoccurring.

Leadership of service

- The RNHRD sat within both the acute surgery and medical divisions within the trust. The divisions had a clear management structure in place. The RNHRD had a management team in place who worked on site at the hospital.
- The hospital manager had been in post since the trust acquired the RNHRD and staff spoke positively about their support and guidance. Staff said they were visible in the hospital and always available when needed. Staff felt the management style of the hospital manager was welcoming, inclusive, approachable and had had a positive impact during a period of change.
- Violet Prince Ward was managed on a day to day basis by a charge nurse and senior registered nurses. Staff spoke of good communication between the ward team and also with other teams who provided care and treatment to the patients on the ward.
- We spoke with porters who were permanently placed at the RNHRD. They did not meet with their managers who only attended RNHRD, if there was an issue and we were told all management support was provided by telephone only. However, we observed and staff confirmed, that the hospital manager provided support and guidance to them when necessary during the course of their shifts.
- The domestic staff managers were based at the RUH main site but visited the RNHRD to meet with staff on a regular basis. Staff commented they saw their managers at least twice a week and felt supported and part of the wider trust domestic service team.
- Staff we spoke with were aware of the role of the trust board and had seen board members during visits to the hospital. The chief executive had an office at the RNHRD and visited the hospital at least once a month where staff found him to be approachable and communicative.
- Prior to and since the trust had acquired the RNHRD, staff had been consulted and informed about the process. Whilst a number of staff were unhappy about the changes at RNHRD and the eventual transference of all services to the main trust site in Bath, they were well informed about the process and made positive comments about the transition process that had taken place so far. Some staff commented they would not be able or willing to transfer their place of work when this time came.

Culture within the service

- Staff were consistently positive and proud about working at the hospital and the atmosphere and team working ethos that was present.
- Staff believed the service provided at the RNHRD was excellent and were proud that patients were referred to them nationally and internationally, which they considered to be as a result of their excellent reputation.

Medical care (including older people's care)

- Staff and patients reported a friendly and welcoming atmosphere at the RNHRD. Staff spoke of a family feeling to the hospital.
- All levels of staff said they felt a valued part of the team. There did not appear to be any barriers to inclusivity, no sense of hierarchy and evidence that multidisciplinary team working was in effect in all departments.
- The hospital had won an award in the best place to work 'specialist category' in the national staff survey run by the national journal - The Health Service Journal in 2015.

Public engagement

- Comment cards were available on the ward for patients and visitors to voice their opinions. We saw a box on the ward was available for completed cards to be posted in and this contained a significant number of completed cards. Staff we spoke with were unaware of when the box was emptied and any action that had been taken as a result of the comment cards.
- A notebook was available in the dining or day room for patients to leave their comments. We saw that two comments had identified a request for a cooked breakfast although staff we spoke with did not think this had been actioned.

Staff engagement

- The trust held an open staff meeting once a month at the RUH to which any staff member could attend to receive updates and information from the trust. There was also a monthly open staff meeting held at RNHRD. This meeting was generally well attended by approximately 20 members of staff. Staff told us this was a useful way to know of any changes which had occurred or were planned to take place. They added it had been particularly helpful following the acquisition of the RNHRD by the trust.
- We were impressed by the resilience and commitment from the staff who had experienced numerous changes in the year since the RNHRD had been acquired by the trust. Staff were aware there were more changes to take place.
- The director of nursing attended a trust wide nurse's forum which senior nurses from the RNHRD were invited to. This provided the opportunity to share and obtain information.
- The trust held a leaders forum for management staff to attend. There had been good attendance by senior staff at the RNHRD since the trust acquired the hospital.
- There was a regular meeting for all medical staff. We were told all grades attended and junior staff commented they were able to ask questions and voice opinions at the meeting.
- Monthly staff meetings took place on Violet Prince Ward. The minutes from the meeting showed the meetings were well attended by all grades of staff. Agenda items included staffing and recruitment, sickness, infection control, staff training, risk assessment and patient safety and any other business.

Innovation, improvement and sustainability

- The ward staff had responded to the need to provide care and treatment to medical patients form the RUH when the medical wards there were full. Consideration had been given to the patients on a pain management programme on how their needs could be best met when providing care to patients with complex care needs which impacted on the ward.
- Staff had been well supported throughout the transitional change from being part of a small foundation trust to being acquired by the RUH NHS trust. This work will be required to continue as services begin to transfer to the RUH site.
- The hospital had achieved a high standard of care when caring and treating patients with lupus. This had been recognised by the lupus accreditation scheme who had awarded the hospital with the centre of excellence award.

Outpatients and diagnostic imaging

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

The outpatients department located at the Royal National Hospital for Rheumatic Diseases (RNHRD) provides a service to approximately 5,000 new patients each in year. This is in addition to approximately 18,500 follow up appointments. A telephone helpline provided a service for 630 patients last year.

Patients attend the RNHRD outpatients department for care and treatment relating to the following:

- rheumatic diseases
- chronic fatigue syndrome such as myalgic encephalomyelitis (ME)
- cancer related fatigue
- chronic fatigue due to long term conditions such as MS
- ankylosing spondylitis

Occupational therapists and physiotherapists provided clinics and treatments at the hospital.

There was a biologics day case unit on site which was attended by approximately 650 patients throughout the year for treatment. Biologics are medicines which are genetically engineered proteins derived from human genes. They are designed to reduce the inflammation which gives rise to joint swelling and other systems such as seen in rheumatoid arthritis.

An x-ray service was available in the hospital between Mondays and Fridays. The department was closed at the weekends.

Summary of findings

We rated the outpatients services and diagnostic services at the Royal National Hospital for Rheumatic Diseases as good because:

- Staff were encouraged and were confident to report incidents via the trust electronic reporting system.
- Information had been provided to staff regarding Duty of Candour and staff were aware of the principles of the legislation.
- The outpatients and diagnostic imaging departments were clean and hygienic and staff promoted the control of infection.
- Medicines were managed appropriately and stored securely.
- Patients were safeguarded against harm by staff who had completed training and had access to policies and procedures.
- Policies, procedures and practices within the hospital were in accordance with national guidelines and best practice recommendations.
- Staff worked well within multidisciplinary teams in the hospital. Good working relationships were forged with external professionals.
- Staff were aware of the requirement for consent to be obtained prior to the provision of care and treatment to patients.

Outpatients and diagnostic imaging

- Patients received care and treatment from staff who were kind, caring and showed empathy and understanding.
- Friends and Family Test results were positive with the majority of patients stating they would recommend the service.
- The hospital had been accredited as a centre of excellence for Lupus care and treatment.
- The hospital had been awarded the best place to work in the Health Service Journal Awards 2015.
- The trust engaged with the staff and consulted and informed them on the plans to transfer services to the main Royal United Hospital (RUH) site.

However:

- There was a delay for some patients waiting for follow up appointments.
- It was not clear that governance pathways put into place since the RNHRD had been acquired by the RUH NHS trust were fully embedded and effective.

Are outpatient and diagnostic imaging services safe?

Good

We rated safety in outpatient's services as good.

- Staff were encouraged and were confident to report incidents via the trusts electronic reporting system.
- Information had been provided to staff regarding duty of candour and staff were aware of the principles of the legislation.
- The outpatients department was clean and hygienic and staff promoted the control of infection.
- Medicines were managed appropriately and stored securely.
- Patients were safeguarded against harm by staff who had completed training and had access to policies and procedures.

Incidents

- Registered nurses and medical staff were aware of the trust electronic reporting process. They were encouraged and confident to report any incidents or near miss situations they were aware of or involved in. However, domestic staff and health care assistants we spoke with said they would not make a report themselves but would inform a senior member of staff regarding an incident. The policy and procedure regarding incident reporting states that 'ideally the person who was directly involved in the incident should report the incident at the time of the occurrence, or as soon as possible after the event. Where this is not possible, a witness or supervisor may complete the incident report'. It was not made clear why it was not possible for health care assistants and domestic staff to not report incidents themselves.
- Once an incident had been reported, the electronic system informed the sister in charge of the outpatients department and the hospital manager. Additional senior staff such as the divisional manager were also informed of the incident depending on the nature and severity of potential harm to patients and/or staff. This ensured they had an overview of any themes and patterns of reoccurring incidents.
- We were provided with the incident log for the outpatients department. This showed that incidents

were reported appropriately regarding patient and staff safety, transport issues, records and confidentiality of records. The log identified that such incidents were reviewed, investigated when necessary and appropriate action taken to address the situation and reduce the risk of similar incidents reoccurring.

- The hospital manager was copied into all investigations into serious incidents at the Royal United Hospital (RUH) and was involved with any required incident investigation incidents at this hospital. The outcomes and learning from such incidents was discussed at the divisional and governance meetings and subsequently shared with staff through team meetings and email communication.
- We asked staff about the feedback they received following reporting an incident. Staff did not consistently receive feedback following the reporting of incidents.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a regulation which was introduced in November 2014. This Regulation requires the trust to notify the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.
- The trust had nominated a lead member of staff for duty of candour issues and they were based at the RUH. Clinicians had been provided with documentation from the trust and the topic was discussed at postgraduate induction sessions and medical staff meetings.
- The hospital manager had raised awareness of duty of candour amongst the nursing staff during team meetings. Therapists told us they had been provided with information at their staff meetings.
- There had been no formal training provided by the trust regarding duty of candour according to the staff we spoke with. However, the trust provided us with evidence in the form of an email, which showed that a 45 minute training session had been planned for staff at the RNHRD in March 2016.
- The staff had a variable understanding of duty of candour. Not all nursing and medical staff were aware of the terminology duty of candour but were able to explain the process and philosophy.

Cleanliness, infection control and hygiene

- The Patient Led Assessments of the Care Environment (PLACE) scores for 2015 showed the RNHRD scored 97% which was the same as the England national average for the cleanliness of the environment. These assessments are completed by teams of local people who review how the care environment supports patients.
- Staff had access to the trust electronic infection control policies and procedures. Staff confirmed they had completed their infection control training during their induction to the trust.
- Domestic staff were employed by the trust, with a consistent team working at RNHRD. All of the areas we visited appeared clean and hygienic. There were plentiful supplies of cleaning materials.
- The cleaning materials were managed within the Control of Substances Hazardous to Health (COSHH) legislation. We observed when COSHH materials were unattended by staff they were stored in locked cupboards within a sluice which had a key pad entry system. This prevented unauthorised people accessing the cleaning materials.
- Handwashing facilities were in place throughout the outpatients department with soap and antibacterial gel available for use by staff, patients and visitors. Notices were displayed regarding effective hand hygiene to assist in the control of infection. Staff were observed to wash and gel their hands regularly. Patients confirmed staff washed their hands before providing care and treatment to them.
- Personal protective equipment such as gloves and aprons were located throughout the department and we saw the dispensers for these were kept well stocked throughout our visit.
- Equipment that was not for single use only for example; blood pressure monitors, were cleaned after each patient contact. We saw staff use stickers which were signed and dated to show when the equipment had been cleaned. These were clearly visible.
- Sharps bins were in place in all clinical areas for the disposal of equipment which could cause transference of infection and harm to staff and patients. For example, used needles and instruments which could break or pierce the skin. The sharps bins were used in accordance to manufacturer's guidelines and were not overfilled and the lids were kept closed when not in use.

- Staff in the outpatients department were responsible for carrying out hand hygiene audits. These were completed each month on the ward. We were provided with data for January and February 2016 which showed 100% compliance with the handwashing procedures.
- The area where patients received treatment from therapy staff and the biologics day case unit used material curtains to provide patients with privacy, these curtains required washing. Staff told us the curtains were washed routinely and when the bed space was deep cleaned but there were no records available to identify how frequently this took place.

Environment and equipment

- The Patient Led Assessments of the Care Environment (PLACE) scores for 2015 showed the RNHRD scored similarly at 88% compared to the England national average of 90%.
- The wards and departments within the hospital had been reconfigured. However, not all signs had been moved and directed visitors around the hospital inappropriately. For example, physiotherapy and occupational therapy had moved but the signs remained at the previous site and the pain management team occupied space previously used by the head injury unit which had moved to RUH. The signs for the head injury department remained in place.
- Fire extinguishers were located throughout the hospital and in outpatients department. These had been serviced within the last year. This demonstrated they had been checked to ensure they were functional and ready to use when required.
- There were portable oxygen cylinders and suction machines located on all floors of the hospital where patients were provided with care and treatment. These were checked daily by staff to ensure they were fully charged and ready to use.
- Resuscitation equipment was available on each floor of the hospital where outpatients visited. Daily checks were carried out by staff to ensure the equipment was present and correct and ready to use in an emergency situation. The medicines required for use in an emergency situation was stored in tamper evident bags so that staff would be able to quickly identify if any medicine had been removed from the bag. This reduced the risk of medicine not being available when required.
- A log was maintained of medical equipment in use on the ward, including the date of the last service and maintenance. A member of staff from the estates department was based at RNHRD and provided staff with assistance with ensuring the equipment was ready for use and available when required.
- There were rooms available for patients working in groups as part of care and treatment programmes. These were of varying sizes, light, airy and pleasantly furnished.
- Patients commented to us that the décor of the hospital had been improved and updated over the past few months.
- The x-ray department had access to evacuation equipment for use in an emergency.
- The x-ray machine and table were up to date with the servicing and maintenance plan. This equipment had been placed on the risk register due to the age and condition of the machine. There had been concerns expressed by the servicing company as to whether replacement parts would be available should the machine break.
- The hospital gym and hydrotherapy pool was available for use by patients, as part of their care and treatment, subject to satisfactory risk assessments to ensure their safety. The hydrotherapy pool water was checked twice a day and recorded in a log.
- The equipment used in outpatients for care and treatment of patients was maintained by the trust estates department. Stickers were placed on the equipment to show when servicing and calibration had been carried out. Most of the equipment we saw was in date with the maintenance programme but the sticker on one grip strength machine had last been safety checked in 2011 and calibrated in 2013. It was still in use which meant it could provide inaccurate results if the calibration was not correct.
- A café/restaurant was available in the hospital for staff, patients and visitors to use. A wide range of meals and snacks were cooked and prepared on site and available between 12pm and 1.30pm.

Medicines

- The medicines used in the outpatients department during clinics were stored securely in locked cupboards in a locked treatment room.
- Prior to each clinic staff prepared the necessary medicines for the clinic by placing them in a locked trolley in the clinic room for the medical staff to access. Small locked cupboards had been obtained and were to

be fitted to the walls in clinic rooms so that medicines could remain in the clinic rooms. This action was a result from the findings of a recent medicines audit carried out in the outpatient department.

- Medicines were ordered and delivered once a week from the pharmacy at the RUH. Additional orders could be placed when needed and staff reported they received a prompt response from the pharmacy.
- Prescriptions pads were available to doctors in the outpatient department to enable them to prescribe medications for patients to obtain themselves from their local community pharmacy. A safe system was in operation to prevent any misuse of the prescriptions. The prescription pads were stored securely and records were in place to audit when and who removed the pads from the cupboard, who each prescription was for and which doctor signed it. At the end of the clinic the prescription pad was signed back into the cupboard.
- The biologics department provided care and treatment to day case patients. Biologics are medicines which are genetically engineered proteins derived from human genes. They are designed to reduce the inflammation which gives rise to joint swelling and other systems such as seen in rheumatoid arthritis. The medicines themselves are powerful and specific therapies prescribed for individual patients. To reduce risks to patients from these medicines a large number are pre-mixed and therefore do not require staff to mix medication on a daily basis. Additional medication training had been provided for nurses working within the biologics department.
- To reduce the risk of error within the biologics department, colour coded prescription sheets were used. The specialist nurse had the responsibility for prescribing medicines for patients and when absent the hospital doctor took on this duty.
- A number of treatments provided in the biologics department were provided by infusion. To reduce risks to patients, laminated sheets were clearly visible regarding concentrations and flow rates for infusions.
- Emergency medicines were located in the clinics and on each floor of hospital. The medicines were stored in tamper evident bags. This meant staff could see at a glance if they had been opened since the daily check of the medicines had taken place.

Records

- Patients' private and confidential medical records were prepared and delivered to the outpatients department by the medical records staff on a daily basis. They were provided the day before the patient was due to arrive in clinic.
- We saw records were stored securely at all times and not left unattended during clinic times in areas that were accessible to visitors to the hospital.
- At the time of our inspection there were two systems of record keeping in operation as the RNHRD patient records were transferring to the RUH electronic patient record system. This meant that staff who worked in the medical records department were experiencing delays in locating records as they could be stored under either system. The resilience and commitment of staff was demonstrated as clinicians were very complimentary about how this had not impacted on the service provided. Clinicians told us they rarely saw patients for an outpatient appointment without their medical records. They added that if they required an additional set of medical records these always arrived promptly or if they were outside of the hospital in another department, information was provided regarding this.
- Therapy staff kept detailed paper records of all care and treatment provided together with a forward plan for the patient. Records were stored in a locked room and in a locked department when no staff were present.
- Risk assessments were completed for patients when necessary. For example, prior to receiving care and treatment in the hydrotherapy pool.

Safeguarding

- Staff had access to the trust policy and procedures regarding safeguarding adults and children, and had completed safeguarding training as part of their mandatory training.
- Information was displayed in the department which provided guidance and prompts for staff regarding domestic violence and the action they were required to take should they suspect this affected any of their patients. Staff we spoke with were knowledgeable about the process and were confident patients would be supported appropriately.
- Information for patients was displayed in the waiting area on whom they could contact if they did not feel safe.
- We reviewed the care and treatment records for five patients who had been provided with care and

treatment by the occupational therapy team. We saw evidence which showed the occupational therapist had taken appropriate action and referred one patient to the safeguarding team, who had presented with clinical signs which triggered a safeguarding concern.
- We observed physiotherapy staff assessing a new patient prior to the commencement of treatment. The assessment included questions to ensure there were no potential safeguarding issues for the patient at their home.

Mandatory training

- The electronic training records identified that the mandatory training consisted of:
  - Blood Transfusion Processes,
  - Conflict Resolution,
  - Equality and Diversity,
  - Fire,
  - Health and Safety,
  - Corporate Induction,
  - Local Induction,
  - Infection Prevention and Control,
  - Information Governance,
  - Mental Capacity Act and Deprivation of Liberties,
  - Moving and Handling,
  - Resuscitation
  - and Safeguarding.
- Not all staff were up to date with the mandatory training programme. Electronic records we reviewed showed that out of seven members of the nursing staff, three were out of date with their fire training, record keeping and information governance. The rest of the nursing staff were up to date with their training.
- Of the imaging support staff, only 40% had completed moving and handling training. This meant that a large number of staff and subsequently patients were at risk or receiving care from staff who were not up to date with training and skills when moving and handling patients or stationary loads. The bank staff who worked at the RNHRD and the imaging support staff were not up to date with other mandatory training such as resuscitation, safeguarding adults and children, and infection control and prevention.
- Staff we spoke with were confident they were up to date with their mandatory training. They were made aware of when their training was due as the electronic system sent a reminder email to both the member of staff and their line manager. This enabled managers to monitor the training for staff. Two managers we spoke with commented that the electronic system did not always accurately reflect the training which had been completed by staff. We were shown examples of where the system showed a member of staff was out of date for specific training but the manager was able to evidence that the training had been recently updated and completed.

Assessing and responding to patient risk

- Risk assessments were completed where necessary for patients attending the outpatients and x-ray departments. For example, we saw risk assessments relating to the moving and handling needs of patients.
- Detailed hydrotherapy risk assessments were completed and required prior to using the hydrotherapy pool as part of the patient's planned care and treatment. These were filed in the patient notes.
- Emergency evacuation equipment was in place in the outpatients and x-ray departments. There was equipment available to be able to assist patients out of the hydrotherapy pool should they become unwell.
- Emergency equipment was available in the department should a patient become acutely unwell.

Nursing staffing

- The outpatients department had two vacancies for nursing staff. They were in the process of recruiting one whole time equivalent (WTE) health care assistant and 0.6 WTE registered nurses.
- Bank staff were used to cover gaps in the duty rota or permanent staff worked additional hours. This ensured clinics were covered appropriately.
- Specialist nurses held clinics to which patients were booked into. This provided support to the medical staff and assisted the clinic waiting lists to be reduced.
- Staff who worked within the outpatients department gathered for a briefing about the planned clinics and information relating to the department each morning.

Medical staffing

- Consultants managed their own clinics supported by specialist doctors, registrars, senior house officers and specialist nurses.
- There was a consultant rheumatologist on call at all times and during the day. Doctors were available on the ward to offer additional support for example, in an emergency situation.

Outpatients and diagnostic imaging

- There was a backlog of appointments which meant some patients were overdue their clinic appointment. A business case had been put forward to achieve extra consultant hours to reduce this delay.

Major incident awareness and training

- Emergency evacuation equipment was located throughout the hospital and where outpatients attended. Staff received training on how to use the equipment during the annual fire drill. Staff we spoke with were confident regarding the location of the equipment and when they would be required to use it. However, two members of staff said they would not be confident or feel competent to use the equipment without direction in an emergency.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

- Staff were provided with guidance through the trusts policies and procedures which were in line with national guidance and legislation.
- Staff were encouraged to undertake role specific training to ensure they were competent and provided a high standard of care and treatment.
- Staff worked well as a multidisciplinary team both within the hospital and with external professionals.

Evidence-based care and treatment

- Staff we spoke with were aware of the policies and procedures which provided them guidance and information when delivering care and treatment to patients. The policies and procedures were in line with national guidelines such as those made by the National Institute for Clinical Excellence (NICE). NICE provide national guidance and advice to improve health and social care.
- We saw evidence that NICE guidelines were referenced in divisional and governance meeting minutes. Staff told us this was to ensure that current practice at the hospital was in line with national guidance. When guidelines changed, discussions took place at the divisional and governance meetings to decide how the changes affected practice.
- Staff referred to the National Society of Rheumatoid Arthritis guidelines. A number of staff were members of the society and were provided with regular updates in national guidelines from the society.
- The hospital provided a self-management programme for patients with the long term condition rheumatoid arthritis. The content of the programme was in line with guidance and recommendations from the National Rheumatoid Arthritis Society and the Department of Health. Prior to the programme and following completion, patients were asked to complete a health education impact questionnaire. The outcomes were analysed and compared to the national average. We were provided with a recent audit report which identified positive outcomes for patients who completed the programme, the report showed behavioural movement between the start of the course and at the follow up. Patients made positive comments regarding the programme and how it had been relevant. Specific comments made were; “worth the time and effort” and that the course had provided the opportunity to put theories into practice to help manage their condition.
- A local audit had taken place of the standard of the completion of patients' medical records. We found the most recent audit had made some recommendations regarding the need for the patient identifiers and the consultants name to be identifiable on each page.
- A local clinical audit had taken place to review the patient pathway against the referral and access criteria at the hospital for patients with complex regional pain syndrome. This had found that compliance to the standards was high and therefore practices were not changed.
- National guidelines had recently been received regarding the treatment with medicines of patients with rheumatoid arthritis and ankylosing spondylitis. A direct email alert had been received by relevant staff and a meeting had been planned to review the trusts practice and if any changes will be needed.

Pain relief

- We observed that the physiotherapy and occupational therapy staff used a pain assessment tool which included standard baseline measurements to effectively assess the patient’s experience of pain.

- Detailed records were maintained for patients who attended the pain management programmes at the hospital. The records identified coping strategies discussed with the patient and feedback from the patient.

Patient outcomes

- The hospital had been awarded as a centre of excellence for lupus. This was based on criteria assessed by the national lupus organisation which the hospital had to meet. The criteria included, number of consultants with lupus specialist knowledge, the appointments system, quality of explanations to patients, the information given to patients regarding the side effects of investigations and the availability of dedicated nurse specialists.
- The occupational therapists were participating in the national osteoarthritis of the thumb therapy trial. They were experiencing positive results for patients.

Competent staff

- Two nurses working at the RNHRD were due to revalidate their nursing registration with the Nursing and Midwifery Council (NMC). The trust had appointed a lead nurse to support staff with the new scheme of revalidation for nurses. Training had been provided by the lead nurse and also the union representative. The hospital manager had spoken with trained nurses to ensure they were confident with the process of revalidation. Two nurses we spoke with confirmed they had been well informed by the trust about the revalidation
- The trainee doctors at the RNHRD come from the local NHS Deanery. An NHS Deanery is a regional organisation responsible for postgraduate medical and dental training, within the structure of the National Health Service (NHS). A consultant at the hospital provided support to the trainee doctors both at the hospital and the Deanery. Junior doctors we spoke with were positive about working at the RNHRD regarding the experience and training opportunities they were provided with.
- The hospital had been awarded the 'Lupus centre of excellence'. Part of the criteria assessed was the number of consultants with lupus specialist knowledge.
- The occupational therapy department was working on a framework for reviewing and ensuring the competency levels for less experienced staff. The framework was based on a national model.
- There was regular supervision for all occupational therapists together with an annual appraisal.
- Less experienced therapy staff were able to carry out joint appointments with more senior staff and the patient referrals were screened prior to allocation to a staff member. This was to prevent, as far as possible, junior staff being responsible for patients with complex care needs.

Multidisciplinary working

- The culture at the hospital enabled every member of staff we spoke with to feel part of the multidisciplinary team. All staff commented that they were able to speak with any other member of staff irrelevant of their role regarding the care and treatment of patients at the hospital.
- The complex regional pain syndrome (CRPS) service held a weekly multidisciplinary meeting. We attended this meeting during our inspection and found the multidisciplinary working within and following the meeting to be outstanding. Internal and external professionals attended the meeting including; the clinical psychologist, occupational therapist, physiotherapist, Macmillan nurse, nurse specialist for pain services, research nurse, the ward charge nurse and the consultant. Links with other professionals were made and feedback from them was discussed at the meeting if they were not able to attend. For example, GPs, adult social care services and therapists from the community both locally and nationally.
- The CRPS service followed a holistic multidisciplinary working model which was based on patient goals and expectations. Options for the patients discharge and support post discharge was discussed at length both within the meeting and with the patient.
- The staff at the RNHRD worked well with external organisations for example when carrying out research on projects led by external organisations.
- The hospital had been awarded a Lupus centre of excellence. Part of the criteria for the award had been the provision of successful multidisciplinary team clinics and combined clinics.
- The fibromyalgia service was run by a multidisciplinary team consisting of physiotherapists, occupations therapists and dieticians.

Seven-day services

Outpatients and diagnostic imaging

- The pain management and chronic fatigue services provided programmes of varying lengths to outpatients who stayed in flats located near to the hospital. The team consisting of occupational therapists, physiotherapists, consultants and psychologists did not work at the weekends. This was planned to provide patients with a break during their intense programmes. Often patients went home for weekend leave or they could remain independently at the flats for the weekend.
- The outpatient service did not routinely provide a service at the weekends. However, at times additional clinics had been booked to reduce waiting times for patients.

Access to information

- The nursing staff had an informal briefing meeting each morning to ensure staff were fully informed of the planned clinics and events for the day.
- The medical records department was located on site and provided an effective and responsive service to the clinical staff. We were told that rarely did a patient attend for a clinic appointment without their medical records being present.
- If clinicians required medical records for a patient, for example if asked for advice on the telephone, the records department responded promptly providing the patients records at short notice.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had an up to date policy and procedure in place relating to consent to care and treatment. The policy and procedure informed staff that valid consent had to be obtained before treatment or examination.
- We observed patients were provided with information and gave verbal consent prior to any tests or treatment received, for example blood being taken.

Are outpatient and diagnostic imaging services caring?

Good

We judged outpatients services for caring as good because:

- Patients gave consistently good feedback for the care and treatment provided to them.
- Staff were observed to be kind, helpful and showed empathy and understanding to their patients.
- Patients were provided with information from clinicians regarding their care and treatment plans.

Compassionate care

- We spoke with 21 patients and 12 of their relatives or representatives who were attending the outpatients department throughout our inspection, to seek their view of the services they had been provided with.
- Patients made positive comments about the care they had received and the kind and helpful staff at the RNHRD. Specific comments included “they are very kind and considerate to me”, “staff are approachable and helpful”, “they treat me with dignity and respect and understand my needs”,
- Staff considered they provided a caring and good service to patients. They gave us examples of when they had received written and verbal feedback from patients.
- Staff were not clear about the outcomes of the Friends and Family Tests for individual departments as the results were compiled at the RUH for the RNHRD as a whole. The NHS Friends and Family Test was created to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. Data provided to us by the trust showed that in January 2016, 40 patients had completed the Friends and Family Test and indicated they were extremely likely or likely to recommend the service. In December 2015 all three patients who responded said they were extremely likely to recommend the pain service they had attended. Ten patients who attended physiotherapy said they were extremely likely to recommend the service. Twenty-four rheumatology patients responded and of those all but one person said they would be extremely likely to recommend the service with the remaining person saying they would not recommend the service. In November 2015 there had been 81 responses with all but one person saying they would be extremely likely to recommend the service.
- We were provided with written plaudits which had been received by the hospital. For example, the self-management programme for patients with

rheumatoid arthritis had received a number of cards and letters which expressed patients' gratitude regarding how the programme had helped them and how kind the staff had been.
- The Bath Centre for Fatigue Services (BCFS) was located at the RNHRD. Feedback was received from 71 patients who attended the programmes run through the 2014-15 year. All of the patients said they would recommend the programme, were very happy or happy with the helpfulness of the team members, and were treated well by the professionals.
- The fibromyalgia self-management programme had received a number of positive feedback plaudits which the service shared with us. Specific comments included "the staff are brilliant and go way above their job role to help and support".

Understanding and involvement of patients and those close to them

- We spoke with 21 patients and 12 of their relatives or representatives who were attending the outpatients department throughout our inspection to seek their view of the services they had been provided with.
- Patients told us they were provided with sufficient information to understand their care and treatment plans.
- We observed that relatives and representatives were included in conversations and discussions with the patient's permission. One patient told us this was useful as it helped them to retain information and discuss with their relative after the appointment. Another patient told us that the doctor came out into the waiting room and asked the patient if they were ready to come into the consulting room and if they wanted their relative to come too. The patient found this reassuring and welcoming.
- During the initial assessment, we observed that patients were asked what they expected and wanted to get out of the treatment and/or self-management programme. Staff engaged with the patient in discussing the potential outcomes for patients.
- Leaflets were available for patients on various conditions and planned treatments. One patient told us they had been provided with a leaflet and the clinician had also explained parts of the leaflet to them highlighting specific bits that were particularly relevant.
- The hospital was a recognised Lupus centre of excellence. Part of the criteria to achieve this award was the quality of explanation to patients and that patients were informed of the side effects of investigations.

Emotional support

- Patients told us that should they have any concerns regarding their care and treatment, they were able to contact the consultant between appointments via the secretary. They commented this was helpful and reassuring.
- Clinical nurse specialists were available to support patients and staff in the management and control of their conditions for example, the pain specialist nurses. The clinical nurse specialists provided patients with verbal advice and support by telephone between appointments.
- Psychologists provided emotional and clinical support to patients attending the outpatients department when required and as part of the self-management programmes in place.
- The hospital was a recognised Lupus centre of excellence. Part of the criteria to achieve this award was the availability of a dedicated specialist nurse and a helpline for support between admissions.
- Feedback received from 71 patients who attended the Bath Centre for Fatigue Services (BCFS) programmes run through the 2014-15 year identified that the patients were listened to by the professionals and that their worries and views were taken seriously. One patient commented "I came feeling so lost/down, came away with friends, tools and realistic expectations." Another patient added "thank you all for your kindness and advice; I have the tools now to hopefully gain some control and move forward."
- During the initial assessment process prior to patients commencing self-management programmes, we saw staff used an assessment tool to indicate the emotional needs of the patient. A depression score was formulated and a referral to the psychologist made if deemed necessary.
- Feedback from one fibromyalgia self-management patient identified significant emotional support had been provided to enable them to manage their mental health and take appropriate steps to seek additional medical help.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services responsive?

Good

We judged outpatients services as good for being responsive because:

- Services were developed in response to patient need for example, the fibromyalgia service.
- Services were developed and delivered close to patients' homes.
- The facilities and environment offered access to patients living with disabilities.
- Patients knew how to make a complaint and complaints were responded to appropriately by the trust.

However:

- There was a delay in follow up appointments for patients.

Service planning and delivery to meet the needs of local people

- Staff and patients expressed concern regarding the planned move of the service to the RUH. The concerns included the location of accommodation for patients who attended the services for pain management programmes. Staff had been provided with opportunities to share these concerns and give their opinions on the requirements the service would need when relocated. For example, the x-ray department had expressed the need for a separate waiting room and treatment room to meet the needs of the current patients.
- The trust provided support and care and treatment for patients living with fibromyalgia. This is a rheumatic condition which is characterised by muscular or musculoskeletal pain with stiffness and localised tenderness at specific points on the body. It had been recognised the services previously provided at the hospital did not fully support or cater for patients with fibromyalgia so a specific programme was designed. Patients could book session times in the morning or afternoon and gym and hydrotherapy sessions are also available in the evenings to enable patients to fit their treatment in at a convenient time to them.
- Virtual clinics using technology such as Skype had been introduced to provide support to patients and professionals outside of the local area.

Access and flow

- New patients referred to the department were generally provided with an appointment within two to five days.
- Patients told us that at times they had to wait for follow up appointments. One person said the time between their appointments had been nine months, yet they had been due to have a follow up appointment at six months.
- Clear systems were in place to manage the booking of outpatient appointments.
- The team who managed the telephone booking of outpatient appointments were based at the hospital. Clinics were planned with the consultants and entered onto the electronic booking system so that staff could clearly see the next available date when answering the telephone booking line.
- Patients who attended the clinic and required an appointment within six weeks were able to book this on leaving the clinic with the reception staff. Patients who required appointments further ahead than six weeks were referred to the booking team.
- The trust did not monitor or audit the waiting time or availability for short term appointments but staff considered patients who required an appointment within this time frame were always provided with one.
- We were provided with figures which showed there were a total of 16,000 follow up appointments per year, with 4,500 new appointments required each year. There was a backlog of processing appointments. There had been 3,000 overdue appointments waiting to be processed in March 2015 and this figure remained the same. Staff considered this had stemmed from a problem in the way data transferred over to a new electronic patient record system.
- There was a typing backlog for providing patients with their appointments. Following the appointment of additional temporary administration staff, this had had been reduced to 548 with appointment letters being sent out within two weeks.
- Under the previous electronic system to reduce the delay in appointments, the consultants reviewed 10 sets of patient notes each week. During this review they

looked at the patients care pathway and ensure the patient was safe to stay on the waiting list or to establish if there was a need to expedite their appointment. This process of review was no longer in operation.
- To reduce the numbers of patients waiting for an appointment, the specialist nurses reviewed patient records on the electronic system and if appropriate booked an appointment for the patient to see them. This reduced the number of patients waiting to see a consultant.
- Patients did not express concerns regarding the length of time they waited at clinics to see the relevant health professional. Two people said that at times there was a short delay but they had always been kept informed during their time at the clinic.
- Waiting times for patients who required an appointment with the occupational therapists were approximately 19 weeks. We were told this was due to one whole time equivalent occupational therapist vacancy. The position had been vacant for the past year but a therapist had recently been recruited and would start work once their recruitment checks were completed.
- The waiting times for patients who required an appointment with the physiotherapist was up to 10 weeks for routine appointments and two weeks for urgent appointments.
- When patients rang the booking line to query their overdue appointment they were offered alternatives. These included the nurse specialist telephone helpline and if necessary telephone communication with the medical staff at the RNHRD. If necessary the specialist nurse or hospital doctor could recommend the booking team provide the patient with an emergency appointment.
- The trust monitored the number of patients who did not attend (DNA) for their booked appointment. For the last year the trust had identified 9% of patients did not attend their appointment.

Meeting people's individual needs

- The Patient Led Assessments of the Care Environment (PLACE) scores for 2015 showed the RNHRD scored 55% against the dementia friendly standards which was worse than the national England average of 75%. The assessments are completed by teams of local people who review how the care environment supports patients.
- Disability access to the hospital was good with lift facilities to access different floors. There were toilets that were accessible to people in wheelchairs and with other mobility aids. Two patients we spoke with said that the helpfulness of the staff concerning their disability was good with one patient adding "it was above and beyond what I expected or had experienced elsewhere." However, one person who used a self-propelling wheelchair said a member of staff assumed they needed help and pushed their wheelchair without asking or mentioning to the patient before doing so.
- Staff had access to policies and procedures which provided them with guidance and direction when caring for patients with complex needs. For example, we saw there was a self-harm policy and staff we spoke with said they had referred to this when caring for a patient who attended a self-management programme in low mood.
- Information leaflets were available on the ward to inform patients about conditions and diseases which affected them. The trust website was a useful resource for further information.
- The chronic fatigue service had changed the colour of the information leaflets and used larger font sizes to enable their patients to access written information.
- Positive feedback was received from patients attending an ankylosing spondylosis course. They commented that whilst attending a group programme they were also treated as individuals with their own outcome wishes. This had a positive impact on their quality of life and ability to manage their own conditions
- The hospital had been accredited with the Lupus centre of excellence award. Part of the criteria for achieving this had been to provide an open door appointments system. This meant that the patients had a named contact to seek advice from between their regular appointments.
- Staff had access to a language line and interpretation services for patients whose first language was not English. They commented that these services were rarely used for their patient group.
- Reasonable adjustments were made for patients who attended the outpatients with specific conditions. For example, patients with fibromyalgia who found mobilising painful and difficult.

Outpatients and diagnostic imaging

- Patients living with learning disabilities were supported to attend the outpatient department and carers were welcomed to attend with the patient if appropriate or an extra member of staff would support the person through the department.

Learning from complaints and concerns

- Patients and visitors to the hospital were advised on how to make a complaint and the contact details for the Patient Advice and Liaison Service (PALS) were displayed clearly. PALS offers confidential advice, support and information on health-related matters. They provide a point of contactfor patients, their families and carers.
- Patients we spoke with knew how they would make a complaint but all said they had never had a need to.
- We reviewed two complaints which had been made and saw that changes in the information provided to patients had taken place as a result of the complaint investigations. A third complaint had led to a change in the clarity of information provided and recorded about patient's treatment and care prior to commencing a pain management programme.

Are outpatient and diagnostic imaging services well-led?

Good

We judged outpatients services to be well led because:

- The trust had engaged with and consulted staff and patients regarding the planned move of services to the Royal United Hospital (RUH) site.
- Action had been taken following the identification of risks to the service.
- Staff were proud and positive to work within the hospital and felt valued by their colleagues.
- All staff had the opportunity to attend regular staff meetings to be kept informed and updated with relevant issues.

However:

- It was not clear that governance systems had been embedded and were fully effective
- Not all staff had regular face to face meetings and support from their line managers who were located on the main trust site at the RUH. Staff chose to seek management support on site from other managers when needed.

Vision and strategy for this service

- The Royal National Hospital for Rheumatic Diseases (RNHRD) had been acquired by the Royal United Hospitals Bath NHS Foundation Trust in February 2015. The vision and strategy for the RNHRD was to move the services provided to the RUH site.
- Meetings and consultation had taken place with staff and members of the public regarding the proposed move and the opportunity had been available for people to give their views on the proposed move.
- The trust informed us that a process of planning was taking place at the time of our inspection to make sure that all services will be transposed into a suitable environment at the RUH. This included work to ensure that integration with the acute services would be managed appropriately in order to meet the needs of a primarily rehabilitation service.

Governance, risk management and quality measurement

- There had been governance pathways put in place within the trust when the RNHRD was acquired. This was to enable the trust board to be made aware of pertinent issues from the RNHRD. The speciality governance meetings were held monthly and any issues were reported at the divisional governance meeting where they were reviewed and either addressed or escalated. If escalated, consideration would be given at the operational governance meeting whose members if necessary could escalate concerns to the management board of the trust. The management board was attended by the executives and senior managers. Information from this meeting was provided at the trust board meetings.
- The rheumatology service at the RNHRD sits within the trust medical division and pain services within the surgical division. The divisional managers for the medical and surgical divisions were based at the RUH and had responsibility for the oversight of governance at the RNHRD.
- The divisional managers for medicine and surgery had been involved in the period of transitional change

following the RNHRD being acquired by the main trust. Changes in working practices had taken place to integrate the RNHRD into trust systems and processes and to monitor the quality and safety of the service provided to the patients.

- The hospital manager had responsibility for monitoring and updating the local risk register and provided information to the appropriate divisions regarding identified risks. The risks could be presented at the three monthly divisional meetings and escalated when necessary to the trust wide risk register.
- We saw evidence that action had been taken in some areas where risks had been identified. For example, the local risk register identified that there had been a backlog of typing follow up appointment letters and the outcomes of appointments to patient GPs. Additional staff, in the form of temporary administration staff and bank staff had been put in place to reduce the backlog and increase the efficiency and safety of the service.
- It was not clear that the governance pathways of risk management were embedded since the RNHRD had been acquired by the Royal United Hospital Bath NHS Foundation Trust. From conversations with senior staff and review of staff and divisional meeting minutes there was not always clear evidence that risks had been reported, escalated and appropriate action taken in a timely manner
- Once an incident was reported, the electronic system alerted relevant staff who were required to be aware of the incident. The nurse in charge of the ward and the hospital manager were made aware of each incident. This enabled them to have an overview of all reported incidents and identify any themes or patterns emerging.
- The staffing levels were available on the trust electronic system which identified when shifts were not filled. This information was flagged to senior managers both at the RNHRD and the RUH.
- We spoke with the named clinician who had the responsibility for clinical governance lead at RNHRD. They considered that the governance systems were good. The clinician stated that they reviewed clinical incidents which had been reported on the trust electronic system. The incidents were reported if necessary, to the divisional governance meetings together with any necessary investigations. Reports were prepared for the monthly divisional governance meetings regarding any root cause analysis investigations of incidents, outcomes from audits and morbidity information.

Leadership of service

- The RNHRD sat within both the acute surgery and medical divisions within the trust. The divisions had a clear management structure in place. The RNHRD had a management team in place who worked on site at the hospital.
- The hospital manager had been in post since the trust acquired the RNHRD and staff spoke positively about their support and guidance. Staff said they were visible in the hospital and always available when needed. Staff felt the management style of the hospital manager was welcoming, inclusive, approachable and had had a positive impact during a period of change.
- The outpatients department was managed by the sister who was a senior nurse who had worked at the hospital for a number of years. They demonstrated a good understanding of the unit and they liaised with and supported the hospital manager.
- The ancillary staff at the RNHRD were employed by the RUH. We spoke with porters who were permanently placed at the RNHRD. They did not meet with their managers who only attended the RNHRD if there was an issue and we were told all management support was provided by telephone only. However, we observed and staff confirmed that the hospital manager provided support and guidance to them when necessary during the course of their shifts.
- The domestic staff managers were based at the RUH main site but visited the RNHRD to meet with staff on a regular basis. Staff commented they saw their managers at least twice a week and felt supported and part of the wider trust domestic service team.
- Staff we spoke with were aware of the role of the trust board and had seen board members during visits to the hospital. The chief executive had an office at the RNHRD and visited the hospital at least once a month where staff found him to be approachable and communicative.
- Prior to and since the trust had acquired the RNHRD, staff had been consulted and informed about the process. Whilst a number of staff were unhappy about the changes at the RNHRD and the eventual transference of all services to the main trust site in Bath, they were well informed about the process and made

positive comments about the transition process that had taken place so far. Some staff commented they would not be able or willing to transfer their place of work when this time came.

Culture within the service

- Staff were consistently positive and proud about working at the hospital and the atmosphere and team working ethos that was present.
- Staff believed the service provided at the RNHRD was excellent and were proud that patients were referred to them nationally and internationally which they considered to be as a result of their excellent reputation.
- Staff and patients reported a friendly and welcoming atmosphere at the RNHRD. Staff spoke of a family feeling to the hospital.
- All levels of staff said they felt a valued part of the team. There did not appear to be any barriers to inclusivity, no sense of hierarchy and evidence that multidisciplinary team working was in effect in all departments.
- The hospital had won an award in the best place to work 'specialist category' in the national staff survey run by the national journal - The Health Service Journal in 2015.

Public engagement

- Patient stories were shared at the trust board meetings. A patient from the RNHRD had been invited and had shared their story of the care and treatment they had received as an outpatient.
- Comment cards were available on the ward for patients and visitors to voice their opinions.
- The hospital had a museum which provided displays of historical medical related artefacts. The museum was run by the hospital volunteers and afforded members of the public opportunities to visit the hospital.

Staff engagement

- The trust held an open staff meeting once a month at the RUH to which any staff member could attend and receive updates and feedback from the trust. There was also a monthly open staff meeting held at RNHRD. The meeting was generally well attended by approximately 20 members of staff. Staff told us this was a useful way to know of any changes which had occurred or were planned to take place. They added it had been particularly helpful following the acquisition of the RNHRD by the trust.
- We were impressed by the resilience and commitment from the staff who had experienced numerous changes in the year since the RNHRD had been acquired by the trust. Staff were aware there were more changes to take place.
- The director of nursing attended a trust wide nurse's forum which senior nurses from the RNHRD were invited to. This provided the opportunity to share information.
- The trust held a leaders forum for management staff to attend. There had been good attendance by senior staff at the RNHRD since the trust acquired the hospital.
- Staff meetings were held regularly. There had been a staff meeting in December 2015, February 2016 and March 2016. Minutes kept of these meetings were brief and while they identified who had attended did not evidence any action taken regarding the issues discussed. The minutes showed that staffing levels, sickness, infection control, mandatory training and patient safety had been discussed.
- There was a regular meeting for all medical staff. We were told all grades attended and junior staff commented they were able to ask questions and voice opinions at the meeting.

Innovation, improvement and sustainability

- Good outcomes were evidenced from the continuing development of psychological supervision models of care and treatment for patients with chronic pain. The staff were innovative and proactive in developing the services meet the needs of patients.
- The fibromyalgia self-management project had secured funding from NHS innovation to enable the trust to develop a franchise model to support other organisations.
- The hospital had been recognised as a Lupus centre of excellence.
- The occupational therapists team were proactive in taking part in research projects.
- The chronic fatigue services were responsive to the needs of patients and changed the format of written information to make it more accessible to patients.
- Staff had been well supported throughout the transitional change from being part of a small foundation trust to being acquired by the trust. This work will be required to continue as services begin to transfer to the RUH site.

Outstanding practice and areas for improvement

Outstanding practice

- The hospital was a centre of excellence for lupus care and treatment.
- The hospital had received national recognition by the Health Service Journal as the best specialist place to work in 2015.
- The Fibromyalgia service had been developed in response to patient need and was now being set up to become a franchised model to share the programme with other trusts.
- The Complex Regional Pain Syndrome (CRPS) service held a weekly multidisciplinary meeting. We attended this meeting during our inspection and found the content and style of the meeting to be outstanding.
- Staff worked well as a multi-disciplinary team throughout the hospital. We saw outstanding team working during a multi-disciplinary team meeting we attended. The patient was at the centre of the meeting, with all professionals striving to promote the health and wellbeing of the patient.
- Patients could attend the RNHRD either as inpatients or staying nearby in self-contained flats, dependent on their care needs and independent living skills. The patients who stayed on the ward were provided with care from the nursing staff. The psychologists who led the pain management programmes provided nursing staff with informal training regarding the philosophy of the programme and how to support patients with their treatment.

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

- The trust must ensure care records and documentation such as risk assessments, referrals to other professionals and clinicians, care plans and monitoring records such as food and fluid charts are in place. The records should be in sufficient detail and maintained appropriately to direct and inform staff on the action they must take to meet the care and treatment needs for patients.
- The trust must ensure that appropriate medical care is provided for patients transferred to the Royal National Hospital for Rheumatic Diseases from the medical wards at the Royal United Hospital.

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

- The trust should encourage all staff to complete incident reports themselves.
- Staff should have access to feedback following the reporting of incidents to ensure that learning takes place after an incident.
- The trust should ensure that records demonstrate the action taken when safeguarding concerns are identified.
- The trust should ensure patients and visitors to the hospital could easily find their way to departments.
- All equipment should be serviced, maintained and/or calibrated to ensure it was fit for purpose and ready to use.
- The trust should ensure all staff were confident and competent to use emergency equipment when necessary.
- All staff should be trained and competent to use emergency evacuation equipment.
- The trust should ensure that patients can access hand washing facilities in every toilet.
- The trust should ensure that fluids for intravenous infusion are not accessible to patients and visitors to the ward.
- The trust should ensure that the mandatory training is kept up to date for all staff.

Outstanding practice and areas for improvement

- The trust should ensure that patients' medical care and treatment needs can be met at the RNHRD before transfers are arranged. The transfer criteria should be complied with.
- The trust should look to reference the guidance by The Law Society in its policy relating to deprivation of Liberty, and ensure there is flexibility within the policy when applying the 72-hour rule.
- The trust should ensure governance systems continue to be embedded.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 1) Care and treatment must be provided in a safe way for service users. (2) without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include – (a) assessing the risks to the health and safety of service users of receiving the care or treatment; (b) doing all that is practicable to mitigate such risks; (c) where responsibility for the care and treatment of services users is shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of the service users. The trust must ensure care records and documentation such as risk assessments, referrals to other professionals and clinicians, care plans and monitoring records such as food and fluid charts are in place. The records should be in sufficient detail and maintained appropriately to direct and inform staff on the action they must take to meet the care and treatment needs for patients.

This section is primarily information for the provider

Requirement notices

The trust must ensure that appropriate medical care is provided for patients transferred to the Royal National Hospital for Rheumatic Diseases from the medical wards at Royal United Hospital.