South Tees Hospitals NHS Foundation Trust

Friarage Hospital

Quality Report

Northallerton
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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	Good
Urgent and emergency services	Good
Medical care (including older people's care)	Good
End of life care	Good
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected the trust from 8 to 10 June 2016 and undertook an unannounced inspection on 21 June 2016. We carried out this inspection as part of the Care Quality Commission's (CQC) follow-up inspection programme to look at the specific areas where the trust was previously rated as 'requires improvement' when it was last comprehensively inspected on the 9-12 and 16 December 2014.

At the comprehensive inspection in 2014 the trust overall was rated as requires improvement for their acute and community services. It was requires improvement for the safe and effective key questions at both hospital locations. The remaining key questions were rated good overall. Community health services were rated good overall, with requires improvement for the urgent care centre.

During this inspection, the team looked at one key question in urgent and emergency care, medicine and outpatients at both hospital locations. One key question in children's and young people at one of the hospitals, three key questions in end of life care at both hospitals, plus two key questions in the urgent care centre and one in community inpatients at one other location. All these services had previously been rated as requires improvement, and all came out as good following the June inspections.

We included the following locations as part of the inspection:

James Cook University Hospital

- Urgent and emergency services;
- Medical care;
- Services for children and young people;
- End of life care;
- Outpatients and diagnostic imaging.

The Friarage Hospital

- Urgent and emergency services;
- Medical care;
- End of life care;
- Outpatients and diagnostic imaging.

Redcar Primary Care Hospital

- Urgent care centre;
- Community inpatients (adults).

Our key findings were as follows:

- Patients received appropriate pain relief and were able to access suitable nutrition and hydration as required.
- There were defined and embedded systems and processes to ensure staffing levels were safe. During this inspection, we did not observe any evidence to suggest the level of nurse staffing was inadequate or caused risk to patients in the areas we visited.
- The trust had infection prevention and control procedures, which were accessible and understood by staff. Across both acute and community services patients received care in a clean, hygienic and suitably maintained environment. However, there were some issues with cleanliness in the discharge lounge at the Friarage Hospital.
- Patient outcome results had improved in areas of sepsis, senior review of patients in A&E with non-traumatic chest injury, febrile children and unscheduled return of A&E patients.
- Staff understood the basic principles of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards and could explain how these worked in practice.

Summary of findings

- There was consistency in the checking and servicing of equipment. However, there was one piece of equipment used in the mortuary at the Friarage Hospital, which had not been adequately maintained.
- Competent staff that followed nationally recognised pathways and guidelines treated patients. There was audit of records to make sure pathways and guidelines were followed correctly.
- Arrangements for mandatory training were good and significant improvements had been made for staff to attend.
- Medication safety was reported as a quality priority in 2016/17 and improvement targets had been set. There were improvements in the management of medicines since our last inspection particularly around effective audit and reconciliation of medicines. We found some inconsistencies in the management of medicines however, the trust nursing and pharmacy team acted promptly and these issues were addressed.
- There was an open culture around safety, including the reporting of incidents. Staff were aware of the duty of candour and there were systems to ensure that patients were informed as soon as possible if there had been an incident that required the trust to give an explanation and apology.
- The trust had developed action plans to improve performance of the 4 hour A&E target, 18 week referral to treatment times, c. difficile and 62 day cancer waiting times. These plans provided the necessary assurance that the trust had the actions and capacity to ensure compliance in 2016/2017.
- The trust had commenced a significant period of transformation and organisational re-design in 2015. There was a newly established senior executive team, and there was a clear ambition from the Board to be an outstanding organisation.
- From 1 April 2016, the trust had moved to a new clinical centre structure. There were five centres, which replaced the existing seven centres. Clinical leadership was strengthened.
- The trust had been in breach for governance and finances; however, they had made significant progress against their enforcement undertakings for both elements.
- The recent changes to the executive team were seen by staff to be very positive. There were improvements in the speed of decision-making and visibility of the senior team in clinical areas.
- The trust was strengthening the patient voice and developing strategies to enhance patient and staff engagement.

We saw several areas of outstanding practice including:

- The trust was developing a detailed programme around patient pathways/flow/out of hospital models. This included developing a detailed admission avoidance model to establish pilot schemes in acute, mental health, community and primary care services. This would ensure patients were virtually triaged earlier in their pathway rather than being admitted to A&E. This would support patients closer to home and in more appropriate facilities, and reserve acute capacity for patients who required it.
- The Lead Nurse for End of Life Care was leading on a regional piece of work for the South Tees locality looking at embedding and standardising education around the 'Deciding Right' tools (a Northeast initiative for making care decisions in advance).

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

In addition the trust should:

- Ensure that processes are in place and understood by mortuary staff at the Friarage Hospital for the maintenance, moving and handling of equipment and transfer of deceased patients particularly out of hours.
- Continue to review the level and frequency of support provided by pharmacists and pharmacy technicians to ensure consistency across wards.
- Ensure that the end of life strategy is approved and implemented and move to develop a seven-day palliative care service.
- Review arrangements for the discharge lounge at the Friarage Hospital in terms of maintaining and cleaning equipment and ensuring the environment was suitable for patients and purpose.

Summary of findings

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?
Urgent and emergency services	Good 	Urgent and emergency care services were rated as good for effective because: There were policies and procedures and these were evidence based. Audits took place to ensure staff were following relevant clinical pathways. Staff were able to access information about clinical guidelines. Information about patients such as test results were readily accessible. Patients were offered pain relief on arrival at the department and regularly during their stay. Patients' nutrition and hydration needs were managed effectively. There was evidence of multi-disciplinary and multi-agency working throughout the department and the department offered a full seven-day service.
Medical care (including older people's care)	Good 	Medical care was rated as good for safe because: There were significant improvements since the comprehensive inspection of the Friarage Hospital in December 2014. There were processes to ensure safe staffing levels on wards and capacity had been reduced to support nurse to patient ratios being safely maintained. During this follow-up inspection, we did not find any evidence to suggest that nurse staffing was unsafe or would cause a risk to patients in the wards we visited. Arrangements for mandatory training were good and significant improvements had been made in order for staff to attend. Trust targets were being met or plans were in place to achieve them. Resuscitation equipment was checked daily. During our inspection, we found inconsistent storage of medicines, however the trust nursing and pharmacy team acted promptly and issues were addressed with an improvement action plan to ensure out of date drugs were not stored in wards, liquid medications were labelled to identify when they were opened and arrangements for drug fridges and temperature recordings were improved.
End of life care	Good 	Overall end of life care was rated as good because:

Summary of findings

Staff delivering end of life care understood their responsibilities with regard to reporting incidents and ensured information and lessons learnt were shared proactively with other colleagues within the hospital.
There were improvements made since the last inspection in documentation of individualised care of the dying documents and appropriately completed Do Not Attempt Resuscitation forms.
However:
Some equipment in the mortuary was not safe for its intended use. Risk assessments for porters and security staff were found to be out of date.
There was no regular audit programme for infection prevention and control in the mortuary.

Outpatients and diagnostic imaging	Good		Outpatient and diagnostic imaging was rated for safe as good because: Departments were clean and hygiene standards were good. Staff ensured equipment was clean and well maintained, so patients received the treatment they needed safely. Incidents were reported using an electronic reporting system and staff knew how to report incidents. Incidents were investigated and 'lessons learned' were shared with staff. Staff had received appropriate training and support through the completion of mandatory training, so that they were working to the latest up to date guidance and practices, with appropriate records maintained.

Friarage Hospital

Detailed findings

Services we looked at
Urgent and emergency services; Medical care (including older people's care); End of life care; Outpatients and diagnostic imaging.

Detailed findings

Contents

Background to Friarage Hospital

The Friarage Hospital in Northallerton, North Yorkshire was one of two acute hospitals forming South Tees Hospitals NHS Foundation Trust. It served a rural population of 122,000 people.

It served an area of 1,000 square miles extending from the North Yorkshire moors to the central Pennines, the borders of York district in the south and the borders of Darlington in the north.

Around 1,100 staff are employed on the Friarage site which provides approximately 160 beds. The Friarage Hospital provided medical, surgical, critical care, maternity, children and young people's services for people across the Hambleton and Richmondshire area. The hospital also provided urgent and emergency services (A&E) and outpatient services.

Our inspection team

Our inspection team was led by:

Chair: Amanda Stanford, Head of Hospitals Inspections, Care Quality Commission

Inspection Lead: Helena Lelew, Inspection Manager, Care Quality Commission

The team included CQC inspectors and a variety of specialists including an A&E nurse, a doctor in medicine, a nurse in medicine, a community nurse specialising in end of life care, a paediatric nurse, hospital managers and a nurse specialising in outpatient care.

How we carried out this inspection

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

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

The inspection team inspected the following core services at Friarage Hospital:

- Urgent and emergency care
- Medical care (including older people's care)
- End of life care
- Outpatient services

Detailed findings

Prior to the announced inspection, we reviewed a range of information that we held and asked other

organisations to share what they knew about the hospital. These included the clinical commissioning

group (CCG), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges, Overview and Scrutiny Committees and the local Healthwatch.

We held a listening event on 1 June 2016 at The James Cook University Hospital to hear people's views about care and treatment received at the hospitals. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection.

We carried out the announced inspection visit from 8 to 10 June 2016 and undertook an unannounced inspection on 21 June 2016.

Facts and data about Friarage Hospital

- The Friarage Hospital provided services to the people in the Tees Valley and North Yorkshire area.
- Between April 2014 and February 2016, the department had 41,223 attendances. Of these, 80% were aged 17 or over and 20% were under 17 years of age.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	N/A	Good	N/A	N/A	N/A	Good
Medical care	Good	N/A	N/A	N/A	N/A	Good
End of life care	Good	Good	N/A	N/A	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	N/A	N/A	N/A	Good
Overall	Good	N/A	N/A	N/A	N/A	Good

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Urgent and emergency services

Effective	Good
Overall	Good

Information about the service

Friarage Hospital is in Northallerton, North Yorkshire. It is a small department that can treat children with minor injuries and adults with more serious acute illnesses, such as chest pains, breathing difficulties and injuries. Patients with very serious illnesses, such as suspected stroke or serious injuries are sent to James Cook University Hospital in Middlesbrough for treatment. Patients can arrive on foot or by road in an ambulance. Within the department, there are two distinct areas where patients are treated. The minors department can treat child and adult patients with minor injuries such as simple fractures and the majors department that treats patients with more serious illnesses or injuries. There are also four resuscitation bays in the department.

A range of experienced consultants and middle grade doctors, emergency nurse practitioners, nurses and healthcare assistants staff the department, seven days a week, 24 hours a day.

The department has a minor injuries unit for children with two bays. There are also four main cubicles, two see and treat rooms and two resuscitation bays. At the time of our inspection, the department was very busy and had invoked an escalation procedure to manage the patients attending.

According to the trust, between April 2014 and February 2016 the department had 41,223 attendances. Of these, 80% were aged 17 or over and 20% were under 17 years of age.

We carried out this inspection because when we inspected the trust in 2014 we rated the effectiveness of the department as 'Requires Improvement'. At this inspection, we only inspected the effectiveness of the department because in 2014 the department was rated as 'good' for our four other domains, 'safe', 'caring', 'responsive' and 'well-led'.

During our inspection, we visited the main A&E department. We spoke with staff including doctors, healthcare assistants and nurses of all grades.

We spoke with nine patients and their relatives. We looked at the records of six patients and reviewed information about the service provided by the trust and other stakeholders such as Clinical Commissioning Groups and Monitor. Additionally, we reviewed national and local audit and survey results.

Urgent and emergency services

Summary of findings

We found that the department was effective. Patients were able to access treatment seven days a week, 24 hours a day delivered by staff from a number of different disciplines such as nurses, doctors and allied health professionals.

Patients were treated by competent staff who followed nationally recognised pathways and guidelines. Records were audited to make sure that pathways and guidelines were followed correctly.

Overall, patients received pain relief in a timely manner and were able to access food and drinks as required.

Staff understood their responsibilities in relation to the Mental Capacity Act (2005), restraint of patients and the treatment of detained patients.

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

Good

We rated effective as good because:

- There were policies and procedures and these were evidence based. Audits took place to ensure staff were following relevant clinical pathways. The trust was taking part in local and national audits and monitoring patient outcomes. The trust had identified a need to improve some audit results where they had outcomes worse than the England average and action was taken to make this happen.
- Staff were able to access information about clinical guidelines. Information about patients such as test results were readily accessible.
- Patients were offered pain relief on arrival at the department and regularly during their stay.
- Patient nutrition and hydration needs were managed and we saw patients being offered drinks and food whilst we were inspecting the department. Patients also confirmed that they were offered food and drinks.
- There was evidence of multi-disciplinary and multi-agency working throughout the department and the department offered a full seven-day service.

Evidence-based care and treatment

- There was a wide range of departmental policies and guidelines for the treatment of both children and adults.
- Departmental policies were based upon the National Institute for Health and Clinical Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines. We looked at a reference tool available to staff and found that guidelines reflected recent updates to NICE guidance.
- We saw evidence that the department followed NICE guidance for a number of conditions such as sepsis, head injury and stroke. Where patients presented to the emergency department with these conditions, pathways were commenced. The department had introduced a sticker to put in patient notes as a response to poor sepsis audit compliance.

- Staff had undertaken a re-audit of the sepsis standards following the results of the RCEM Sepsis audit. The results for Friarage showed that eight of the 12 indicators had improved. Four indicators had deteriorated however the sepsis screening tool and National Early Warning Screening (NEWS) tool had been updated and the critical care outreach team had been introduced at the site. A further re-audit had not yet taken place to measure whether compliance had improved as a result of these introductions.
- The re-audit of Consultant sign off in 2015 showed that all eligible patients were signed off appropriately. This was because the department was staffed by senior doctors.
- Care was provided in line with 'Clinical Standards for Emergency Departments' guidelines and there were audits in place to ensure compliance. Staff acknowledged that results to some audits had been poor in the past but could give examples of work undertaken to make improvements such as introducing new documentation and changing treatment pathways to ensure compliance. The department had also run regular training sessions for staff. These covered areas of non-compliance from audits such as, for example, procedures for conscious sedation within the department.
- Local audit activity demonstrated that re-audit took place in the department, and there was evidence of changes implemented as a result. For example, mandatory fields have been added to the IT system to ensure that patient next of kin details are recorded to assist with appropriate discharge of elderly vulnerable patients from the department.

Pain relief

- Patients were asked if they required pain relief as part of the triage process and it was recorded if patients refused. Patients were checked regularly to see whether they needed further pain relief. Patients we spoke with confirmed that they were offered pain relief. However, on the day of our inspection, the department was particularly busy and we spoke with two patients who had waited more than an hour and had not been triaged. Both patients said they were in pain and would have benefited from pain relief however because they had not seen a health professional, they had not been offered pain relief.
- We saw nurses giving patients pain relief such as paracetamol and ibuprofen using PGDs.
- CQC's national 'Inpatient survey 2015' showed that the trust performed about the same as other similar trusts for whether staff did all they could to control patients pain.
- Of the seven sets of notes reviewed three had pain scores recorded although records showed that those patients who needed pain relief received it in a timely manner.

Nutrition and hydration

- CQC's national 'Inpatient survey 2015' showed that the trust performed 'about the same' as other similar trusts for the quality and choice of food available. There was no specific information relating to A&E.
- We saw and heard staff asking patients if they wanted drinks or snacks and we saw patients being offered drinks and being brought sandwiches.
- Of the seven patients whose records we looked at, there was documented evidence that one had been given a drink and something to eat, for three patients this was not applicable and for two patients, there was no documented evidence that patients had been given anything to eat or drink. One of the patients had only been in the department for a short period; however, one had been in the department for over three hours and was to be admitted to a ward.
- Staff told us that sandwiches, hot meals and beverages were available to patients.
- There were vending machines present in the department that relatives and carers could access and the hospital had a shop and cafe.

Patient outcomes

- The department took part in Royal College of Emergency Medicine (RCEM) audits so that it could benchmark its performance against best practice and other A&E departments. The results of some audits showed that the department needed to improve compliance with RCEM guidelines.
- At out last inspection we identified that the department was not meeting some of the standards identified in RCEM audits. For example, in the recording of vital signs at triage. The department had carried out local re-audit.

This showed that although there was still not 100% compliance, results had improved. The audit was completed in March 2016 and therefore a re-audit was yet to be planned.

- We saw that re-audits had taken place to ensure results had improved because of changes made, such as the sepsis pathway and the introduction of new documentation. There was also an identified consultant lead for management of sepsis.
- In the 2012 Renal Colic audit, the department had not met any of the standards. In July 2015 the latest revision of the suspected renal colic pathway was introduced. Audit of compliance was yet to take place.
- We spoke with managers about the department's clinical audit programme and saw that there was a comprehensive programme of clinical audit in place within the department. We saw that some re-audits based on RCEM standards were planned. There were also other prioritised audit in place, such as: Admission of patients aged over 90, Neonatal antibiotic prescribing and Alcohol Related Admissions to A&E in Under-18s.
- Trauma Audit Research Network (TARN) information was not applicable to this department because the A&E at Friarage did not meet the inclusion criteria.
- Across the trust, the unplanned re-admission rate to A&E within seven days was better than the England average of 7.5% however it had increased from 4.6% in July 2015 to 7% in January 2016. There was no specific data available for Friarage Hospital.

Competent staff

- According to information provided by the trust, between April 2015 and March 2016, 75% of band two to four, 33% of registered nurses 71% of administrative and 60% of medical staff had undergone annual appraisal.
- We spoke with staff about whether they were able to access support and supervision. Staff told us that the department managers supported them to develop their roles. Staff felt well supported and able to discuss clinical issues openly with colleagues and managers.
- Recently qualified staff were given preceptorship (mentoring and support) and newly employed staff shadowed existing staff prior to being counted as a member of the team for staffing purposes.
- We saw that there was a local induction in place for all new staff including temporary staff. The senior nurse in charge had to sign to say they were happy with the competencies of any bank staff used.
- The senior sister worked with staff to ensure that they were competent. Senior members of staff informally monitored staff competencies throughout the year and managers told us that action was taken to address any concerns about staff competencies. This applied to both medical and nursing staff.
- All staff were part of the revalidation scheme and we identified no concerns about compliance within the department.

Multidisciplinary working

- The emergency department teams worked effectively with other specialty teams within the trust, for example by seeking advice and discussing patients, as well as making joint decisions about where patients should be admitted. There were close links with the ambulatory care department and the assessment suite.
- There was good access to mental health clinicians by telephone access to psychiatric liaison staff.
- There was a substance and alcohol misuse liaison team available by telephone to support patients and staff treating them.
- Allied health professionals such as physiotherapists and occupational therapists occasionally attended the department. This meant that patients who needed therapy input or assessment prior to discharge could be seen quickly and efficiently.
- There were links with voluntary services such as Age UK to support patients who needed limited social care input to promote discharge.
- The department worked closely with the ambulance trust, local GPs and the out of hours service to ensure that unnecessary attendances and admissions to the department were avoided.
- We saw that medical and nursing staff worked well together and communicated clearly and effectively about patients.

Seven-day services

- The emergency department offered a seven-day service staffed 24 hours a day, seven days a week by medical and nursing staff. Staff could access support from consultants throughout the 24-hour period through James Cook University Hospital.
- There was 24-hour access to diagnostic blood tests. Radiology tests such as x-rays and scans were carried out as and when needed and were available 24 hours every day.

Urgent and emergency services

Access to information

- Staff were able to access patient information using the electronic system and using paper records. This included information such as previous clinic letters, test results and x-rays.
- Patients transferred to other services or sites took copies of their medical records with them. Additionally, the referring clinician gave a verbal handover to the receiving department to ensure that important details were captured.
- Clinical guidelines and policies were available on the trust intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We spoke with staff about the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards. Staff understood the basic principles of the Act and were able to explain how the principles worked in practice in the department.
- Training figures for MCA training were at 41% for nursing staff and 50% for medical staff. The trust target was 90%.
- Staff we spoke with understood the need to obtain consent from patients to carry out tests and treatments. Staff told us that they implied consent when the patient agreed to a procedure and we saw evidence of staff explaining procedures to patients and patients agreeing to them.
- Staff understood the principles of Gillick and Fraser guidelines and assessing competency to make decisions when discussing treatment options with patients under 16 years of age.
- The department had access to a suite that was suitable for holding patients who were detained under Section 136 of the Mental Health Act.

Medical care (including older people's care)

Safe	Good
Overall	Good

Information about the service

The South Tees Hospitals NHS Foundation trust provides medical care, including older people's care across two sites, the James Cook University Hospital (JCUH) in Middlesbrough and the Friarage Hospital in Northallerton.

The trust has made significant changes to its management and governance structures since the last comprehensive inspection. Re-organisation of services and staffing were on-going and during this follow up inspection the new management team in medical care, as part of the community care centre, were establishing roles and responsibilities.

Medical care was managed under four centres at South Tees Hospitals NHS Foundation Trust. The community care centre included care of the elderly, respiratory, endocrinology, rheumatology and dermatology. The specialist care centre included haematology, cardiology, neurology, spinal injury and stroke care. The planned care centre included gastroenterology and acute medicine was now managed under the urgent and emergency care centre. The Friarage Hospital included acute medical wards, a stroke rehabilitation unit and a clinical decision unit (CDU) within integrated medical care.

We carried out an inspection in December 2014. We rated medical care overall as good, with the safe domain rated as requires improvement. We had concerns around safe nurse staffing levels especially overnight, inconsistent management of medicines, poor compliance with mandatory training and poor checking processes for resuscitation equipment. We rated the domains effective, caring, responsive and well-led as good and therefore did not inspect these areas during our follow-up inspection.

We reviewed 13 care records and 10 medicine prescription charts. We spoke with six patients and 15 staff including ward managers, health care assistants, domestic staff, student nurses, doctors, pharmacists and pharmacy technicians. We reviewed performance data about the trust and listened to stakeholders.

Medical care (including older people's care)

Summary of findings

During this inspection, we inspected safe and rated the domain as good, noting significant improvements since a comprehensive inspection of the Friarage Hospital in December 2014.

There were processes to ensure safe staffing levels on wards and beds numbers had been reduced to support nurse to patient ratios being safely maintained. During this follow-up inspection, we did not find any evidence to suggest that nurse staffing was unsafe or would cause a risk to patients in the wards we visited.

Arrangements for mandatory training were good and significant improvements had been made in order for staff to attend and trust targets were being met or plans were in place to achieve them. Resuscitation equipment was checked daily.

During our inspection, we found inconsistent storage of medicines, however the trust nursing and pharmacy team acted promptly and issues were addressed with an improvement action plan to ensure out of date drugs were not stored in wards, liquid medications were labelled to identify when they were opened and arrangements for drug fridges and temperature recordings were improved.

Are medical care services safe?

Good

We rated safe as good because:

- A trust-wide nurse staffing review in 2015 had supported improvement in ratios of nurses to patients on day and night shift.
- Ward sisters and matrons were experienced and knowledgeable about nurse staffing levels and the action plans that had been implemented in 2015. Nursing staff we spoke with told us of improvements in nurse to patient ratios, additional support in place especially during night shifts and closure of beds. We did not have concerns about staffing levels on review of historical and current rotas.
- Ward sisters had organised training plans and we reviewed training attendance rates, which were good for 2015/16 with strategies in place to achieve annual mandatory training targets for all staff. Display of training information was consistent and available across all wards as senior nursing staff had good access to ward level data for attendance rates. A new approach to mandatory training had been implemented by the trust since our last inspection, and staff we spoke with told us it was working well to improve attendance and achievement of trust targets.
- Wards had improved systems and processes for checking resuscitation trolleys and equipment as part of an action plan from previous inspection findings, staff we spoke with were aware of the learning and improvements. Resuscitation equipment on all wards was checked correctly and trolleys stocked.
- The trust had good systems for reporting incidents staff we spoke with understood the processes. Feedback was given in team meetings and through a variety of approaches taken by ward managers, including social media. Wards had clear display of safety thermometer (key performance indicators) as part of monitoring safe and harm free care and results were positive and closely monitored.
- Wards were visibly clean. Display of information reporting low or improving rates of infection were clear

at the entrances to wards. We observed good compliance with infection control policies and hand hygiene audit data displayed was also good. We observed equipment to be clean and maintained.
- Staff completed patients' records, including individualised care plans and risk assessments. The electronic system for recording and escalating Early Warning Scores (EWS) for deteriorating patients and those at risk was also good. Staff who understood the escalation processes when they had concerns about patients consistently recorded patients' observations.

However:

- In all wards inspected we found out of date medicines and bottles of liquid medicines were open with no system to inform staff of the date of opening, increasing a risk that the drug could be administered beyond its expiration date.
- Inconsistent fridge temperature monitoring was also observed and we noted that clinic rooms were very warm with no recording of room temperature.
- During an unannounced inspection on the 21st June 2016, we found that managers, pharmacy and nursing staff had promptly put an action plan in place across the trust that included the use of a date opened sticker system for bottled liquid medicines and a new system for fridge temperature and room temperature recording. Staff we spoke with had been informed of the changes and communication to staff about the improvements had been shared, actions had been taken and the new system implemented across all wards.
- A discharge lounge had been established in a bay of Ainderby ward. It was untidy and cluttered with broken bed frames and chairs. Items of equipment were not clean and the environment had not been adapted for the needs of patients using a discharge lounge. Nursing staff on Ainderby ward had responsibility for caring for patients in the discharge lounge from 8am to 8pm. Staff we spoke with told us that it was used infrequently. We spoke with senior staff and action was taken to remove broken equipment and screen the remaining items during our inspection. Senior staff we spoke with told us that discussions about the future use of the bay as a discharge lounge were on - going and the trust recognised that the arrangements required review.

Incidents

- The centre reported incidents through an electronic system. Incidents were monitored by each department within the centre and could be broken down further into specialities.
- There was evidence of good reporting systems and consistent monitoring by senior staff. All staff we spoke with were aware of the reporting system, reports were shared in team meetings and as part of staff briefings. We saw minutes of meetings and display of information on all wards inspected. Staff we spoke with told us that there was a good reporting culture amongst the team.
- 566 incidents were reported at the Friarage Hospital in 2015/16 under medicine . The trust categorised incidents according to severity of harm as per trust policy.
- There had been zero never events reported by the trust in 2015/16 in medical care at the Friarage Hospital. A never event has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorised as a never event.
- In accordance with the Serious Incident Framework 2015, the trust reported 60 serious incidents in 2015/16 up to February 2016, which met the reporting criteria, set by NHS England. 32 of those incidents were reported as pressure ulcers with 14 as patient falls with harm or fracture. The Friarage Hospital and medical care reported four major incidents across its departments and those were attributed to falls with harm.
- Across all wards within medicine, there had been 113 moderate graded incidents in 2015/2016, Eight had been reported at the Friarage Hospital. The range of incidents were reported as falls, pressure ulcers and confirmed diagnosis of deep vein thrombosis or pulmonary embolism.
- Arrangements for mortality and morbidity review for the centre were good. Each centre held their own meetings to share incidents and learning. Additional meetings were held at a trust level to strengthen learning across the organisation and staff told us that additional meetings were arranged if issues were identified.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

- Staff we spoke with understood that duty of candour requirements involved being open and honest with patients and staff could describe how to access the trust policy. Ward managers had a good understanding of the duty of candour and explained that they had been involved in investigating and supporting responses and letters of apology to patients and families under this duty.

Safety thermometer

- Safety Thermometer data was clearly and consistently displayed at the entrance of all wards we inspected.
- The rates of pressure ulcers and falls were closely monitored and investigations and action plans were quickly put in place when rates of falls or pressure ulcers increased.
- There were 148 falls reported at the Friarage Hospital across the wards and departments in 2015/16. Wards we inspected had a good understanding of their own rates and these were displayed. Falls remained a priority for the trust and work with a falls strategy team had been implemented. Staff were knowledgeable about mitigating risks to patients and used a variety of approaches to prevent incidence. We saw action plans at ward level for patients at risk and for those that had suffered harm through falls.
- We spoke with senior nursing staff on Ainderby ward who told us that after an increase in falls in May 2016 they had identified falls as the 'focus of the month' this had been communicated in staff briefings, team meetings and a private social media group. A focus on improving risk assessments for patients, supply of appropriate equipment was given priority and closer supervision and support for patients at risk was put in place.

- The trust has seen a 24% reduction in avoidable category 3 and 4 pressure ulcers from April to December 2015. A 10% reduction in category 2 pressure ulcers was also reported for inpatients. There has been an increased focus on the prevention of pressure ulcers across the trust. The trust reported 62 catheter associated urinary tract infections (CAUTI) in medical care in 2015/16. This incidence had increased over 2015/16. Of thirteen records reviewed, we noted staff completed all venous thromboembolism (VTE) risk assessments within the first 24 hours of admission. There was a newly developed VTE care pathway in place across sites. We also observed in all patients who required VTE treatment, staff had prescribed the relevant prophylaxis. The trust reported four VTE incidents in medical care at the Friarage Hospital in 2015/16.

Cleanliness, infection control and hygiene

- All wards inspected were visibly clean. We spoke with domestic staff and reviewed cleaning schedules for routine ward cleaning. We observed systems to indicate equipment was clean and ready for patient use. There was good waste management systems and poster display information to guide staff. Disposal of sharps was observed as compliant with trust policy.
- We observed staff taking opportunity for washing their hands and using hand sanitising gel between patient contact. We observed staff comply with uniform and 'bare below the elbows' policies. Hand hygiene compliance was greater than 95% across wards we inspected and a commitment to hand hygiene campaigns continued.
- There was good provision of isolation rooms, with six occasions reported in 2015/16 where isolation was not available for patients with suspected or actual infection. Personal protective equipment was available for staff and we observed staff apply principles of infection prevention and control.
- Clear signage was present for infection control risks and staff and patient information was observed in ward areas.
- The trust were monitoring and responding to the rates of clostridium difficile to ensure incidence did not continue to breach trust targets. At the end of February 2016 there had been a total of 60 cases against a target of 50 for 2015/16. In medical care this had been reported as a total of 29 in 2015/16 to time of reporting, an increase from 23 cases in 2014/15. In the Friarage Hospital seven cases of detected clostridium difficile had been reported with four incidence reported in the clinical decision unit (CDU). Two cases were reported on Ainderby ward, with one on Romanby ward. There had been nil reported Methicillin Resistant Staphylococcus Aureus (MRSA) in 2015/2016.
- Wards displayed the monthly and annual rates of infections as part of a wider display of key performance indicators and 'know how you are doing' (KHYD) information boards on each ward. Staff we spoke with were knowledgeable about their areas and when

preventable infections had occurred or rates increased local action plans were implemented and communicated with staff. We spoke to staff about changes in care pathways to guide care for assessment of patients with diarrhoea. A stool chart had been re-designed and this had been communicated to staff to improve assessment and isolation of patients. All staff had attended commode-cleaning training.

- The trust had a clear approach to advising visitors not to attend the ward if they had been unwell. This was in order to reduce the spread of infection.
- Mandatory training within the trust included an infection control module and staff accessed training online and in face-to-face sessions with the infection control team. 95% of staff in the centre had completed this training so far this year. There was good attendance rates on the wards we inspected at the Friarage Hospital.

Environment and equipment

- We checked 17 items of equipment and found all items to be clean and well maintained with annual checks and labelling in place. Ward staff checked resuscitation equipment daily and we found consistent checks and systems across all wards, in previous inspections, we had found this to be inconsistent across wards.
- Ward matrons performed regular environmental audit and in wards we inspected compliance was reported as greater that 90%. Action plans were developed to improve standards against the environmental audit when necessary.
- The environmental cleanliness and storage of equipment in the discharge lounge on Ainderby ward was poor. The ward bay that had been adapted to use as the discharge lounge was untidy and cluttered with broken bed frames and chairs. Items of equipment were not clean. We informed senior staff and some of the issues were resolved, equipment that was not in use was screened off and other items had been cleaned. Senior staff we spoke with told us that discussions around concerns and the future use of the bay as a discharge lounge were on going.

Medicines

- Clinical pharmacists and pharmacy technicians provided medicines management support and their role included medicines reconciliation on patient admission, regular prescription reviews and stock management in wards.
- Medication safety was reported as a quality priority in 2016/17 and improvement targets had been set. Monitoring was planned through the centre quality dashboards.
- We previously reported 60% compliance against The National Institute for Health and Care Excellence (NICE) guidance with medicine reconciliation for patients within 24 hours of admission. During this follow up inspection, compliance had improved to 90%.
- Wards we visited had safe central system for key storage and access.
- Controlled drug (CD's) storage and checks were good in all wards. An updated controlled drugs policy had been ratified by the clinical standards committee and shared with staff on the trust intranet site.
- We reviewed five prescription charts. Medical and nursing staff completed the charts legibly. All prescription charts had patient allergies recorded and we found no discrepancies or missed doses.
- A monthly programme of medicines audit against trust policy was embedded to include, missed medication audits, antibiotic prescribing and controlled drug audit. Audit results were good and where improvements could be made, an action plan was produced and measures put in place to improve standards. In May 2016, patients own CD's should be recorded separately to ward stock and this had been implemented. We observed separate 'patient own' log books during the inspection. Minutes of audits were produced and shared with teams. Community care achieved 99.4% compliance with acceptable antibiotic regime prescriptions in May 2016.
- A comprehensive trust approach to audit of missed doses of medicines had been taken in March 2016 in order to inform development of future policy, assess the current rate of missed doses and improve compliance and awareness amongst staff.
- In response to the National Patient Safety Agency (NPSA) 'alert 'reducing harm from omitted and delayed medicines in hospitals' the trust identified a list of critical medicines where timeliness of administration was crucial. Learning from the audit had been shared

across the trust. However, wards at the Friarage Hospital were not included in this audit, and therefore it was not clear how the site would be included in the follow-up work around missed doses.

- During the inspection, we found out of date patient own medicines stored in cupboards in Rutson stroke rehabilitation unit and Ainderby ward. We found out of date medicines and bottles of liquid medicines open with no system to inform staff of the date of opening. This increased a risk that the drug could be administered beyond its expiration date.
- Systems to monitor the storage of medicines requiring refrigeration were inconsistent across wards. Staff we spoke with did not understand when they would ask for advice from pharmacy staff or if recorded temperatures were outside an indicated safe range. Temperatures were recorded inconsistently. We brought the issues to the attention of senior staff.
- During the unannounced inspection on the 21st June 2016, we found that managers, pharmacy and nursing staff had promptly put an action plan in place to address the inconsistent practices across the trust. This was implemented to include, use of a date opened sticker system for bottled liquid medicines, additional checks as part of ward audits and a new system for fridge temperature and room temperature recording. New room temperature thermometers had also been installed. Staff we spoke with had been informed of the changes and communication to staff about the improvements were on-going, however the actions had been taken promptly and new system implemented across all wards.

Records

- We reviewed 13 patient care records during our inspections. Overall, we found records to be well organised, up to date and clear. We saw good examples of legible daily entries and reviews of patient treatment and care.
- Staff recorded outcomes from reviews and discussions with the multidisciplinary team, patients and their families. We saw good evidence of individualised care plans, appropriate risk assessments and discharge planning for patients.
- Health records were stored securely in all wards inspected.
- The trust had implemented and embedded the use of an electronic system for recording of patient physiological observations. Staff had a good understanding of the use of equipment and how the system supported monitoring and recording changes in patient observations.
- We reviewed specific stroke care and end of life care pathways for patients. Pathways were complete in all cases we reviewed.
- We noted good examples of Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) documentation with evidence of discussion with patients and family.
- Staff attended information governance training as part of the 'Core 7' mandatory programme. Attendance rates across wards were greater than the trust target of 95% at the time of inspection.

Safeguarding

- Provision of safeguarding training was good across the trust and staff could access training for safeguarding adults and children at level one and two through the 'Core 7' mandatory training system. In May 2016 it was reported that 67% of staff overall had attended training. 100% of staff requiring level 3 safeguarding training had attended it.
- During the previous inspection, figures provided by the trust indicated that there was poor and inconsistent attendance by staff to safeguarding courses for adults and children. We found that this had improved. Staff across wards we inspected had achieved or had a clear plan to achieve targets for attendance with greater than 75% overall attendance rates and targets to achieve the 90% target.
- Staff we spoke with had awareness of their responsibilities and knew whom to contact regarding safeguarding concerns. Policies were available online and staff knew how to access them.

Mandatory training

- Mandatory training provision had been redesigned to include a wider range of subjects over a single day study and as online modules. Staff we spoke with told us the new system was improved and working well to support staff achievement and attendance to essential training. At the time of inspection, overall compliance was greater than the trust target of 90% in wards inspected. Medical staff had achieved 98% of staff attendance. The trust teams had worked hard to improve planning and achieve compliance in 2015/16.

- The Core 7 mandatory training package included: basic life support, blood transfusion, conflict resolution, dignity at work, fire safety, health and safety and patient well-being, Infection prevention and control, information governance, manual handling, mental capacity act, safeguarding level 1 and 2 for vulnerable children and adults. There was also evidence of training for VTE assessment and a comprehensive medical devices training and competency programme was organised for nursing staff.
- We saw clear and consistent poster displays of attendance and plans for staff attendance on each ward we inspected in senior nursing offices. Senior staff had clear objectives to achieve annual targets for appraisal and mandatory training for staff. Wards were comparable and had achieved or were on target to achieve attendance.

Assessing and responding to patient risk

- All wards used an early warning score (EWS) system to help identify and manage patients whose condition deteriorated. An electronic system was embedded to support the recording and monitoring of physiological observations and risks to patients**.** Staff we spoke with knew how to follow escalation policies if they had concerns about patients. Staff we spoke with told us that they had good relationships with medical staff. All five records we reviewed had accurate recording of EWS.
- The critical care outreach team (CCOT) and hospital out of hours team continued to support staff with concerns about patients who were at risk of deteriorating.
- A range of risk assessments were completed for patients on admission and during their hospital stay. Risk assessments we reviewed in care records were thorough and individualised.
- We did not inspect the clinical decisions unit (CDU) as part of this follow-up inspection however provision of four beds for cardiac monitoring and telemetry existed in CDU should a patient require closer observations or monitoring.
- Handover arrangements were good between nursing and medical teams and staff had an understanding of patients at risk across the wards.

Nursing staffing

- The hospital had adopted the Safer Nursing Care Tool (SNCT) to determine the required levels of nurse staffing for each ward. It was reported to us that a further and more comprehensive review of nursing establishments and skill mix, with reference to concerns around nurse to patient ratios and safe staffing levels took place in 2015. As part of the review, a number of actions were implemented including: three nurses on nights if wards had more than 24 beds or patients, improved escalation policies, increased sharing of staffing across wards and regular meetings within the centre to establish any staffing problems promptly. The ward manager role was established as supervisory, allowing for greater oversight of ward staffing issues.
- We found much improvement in planned and actual staffing levels and ratios of nurses to patients with one nurse to six or eight patients during the day and one nurse to a maximum of 12 patients overnight, with additional healthcare assistant support and good escalation policies. Nurses assessed patient acuity levels and planned to staff wards according to demands. There were plans, which had been partly implemented, to increase to three registered nurses overnight, which would improve ratios further.
- We reviewed historical and current paper and electronic rotas and establishments on each ward, which corroborated improved nursing staffing levels during day and night shift. We noted that Ainderby ward had reduced its bed capacity from 27 to 22 beds, however the staff did have responsibility for care of the patients in the discharge lounge from 8am to 8pm, and this area had been adapted from the previously closed bay. The Rutson stroke rehabilitation unit had increased its beds from 19 to 25 to accommodate the closure of beds in Lambert ward in Thirsk. Staff had been re-deployed as part of the closure.
- Vacancies had improved across medicine since 2014 although this was reported as a consistent challenge for this service, especially in elderly and acute medical wards. The vacancy rate at the time of reporting was 90 WTE qualified nursing staff across the medicine service, approximately 6% vacancy rate overall against planned establishments. Trust staff covered shortfalls working additional shifts when required and NHS Professionals was utilised as a nurse bank provider. Minimal or zero agency nursing staff were deployed in the wards we visited.

- Sickness was closely monitored and managed by senior nursing staff and the trust had implemented earlier reviews for staff as part of a new sickness absence management policy.
- Handover was observed to be organised and thorough. Discussion between the nurses in charge, a cascade to staff and board round discussion with the MDT to identify priorities and risk for each patient was observed. Nursing staff communicated well with medical colleagues and members of the MDT.
- Staff displayed planned and actual staffing numbers on whiteboards at the entrance of the ward and the wards were fully staffed at the time of inspection.
- The service was actively recruiting nursing staff and had filled a number of vacancies with nursing staff from outside the UK. Recruitment however was reported as an on-going challenge by staff. Ward managers were knowledgeable about team vacancies, plans for new staff commencing in post and positive ways in which they would be supported on commencement.

Medical staffing

- The ratio of consultants to other medical staff continued to be better than the England average. There were recognised gaps in recruitment to registrar and junior doctor levels, senior staff told us that all other grades were staffed appropriately.
- There was a high level of medical registrar level locum usage at the Friarage Hospital; approximately 40%. A policy clearly outlined processes for the use of locums in the trust. This had been reported in 2015 as due to recruitment difficulties at the site. Staff we spoke with told us that the policy was followed and locum staff were known to the teams and familiar with the Friarage Hospital.
- The consultant cover and junior doctor availability was appropriate. Consultants were visible and accessible to junior staff. Consultant cover was provided as an on call service and was not routinely on site overnight. Junior doctors we spoke with during this inspection reinforced previous reported findings around feeling supported by consultant colleagues.
- Medical registrar, based in CDU with support from a foundation year doctor and nurse practitioners, provided overnight cover. All were integral to the hospital out of hours team.
- Medical staff were visible and involved in handovers and daily ward rounds and review of patients. We observed good communication amongst staff at handovers and safety briefs.

Major incident awareness and training

- There was a major incident plan in place and staff we spoke with knew how to access policies and support. There was also a winter management plan in place.
- The trust and its partners in the locality had escalation/ resilience plans which were followed as required. The North East Escalation Plan (NEEP) was known to staff we spoke with.
- We saw that the trust had appropriate policies in place with regard to business continuity and major incident planning.

End of life care

Safe	Good
Effective	Good
Well-led	Good
Overall	Good

Information about the service

Nursing and medical staff throughout the Friarage Hospital delivered end of life care (EOLC). There were no dedicated beds within the hospital for specialist palliative care.

The SPCT (specialist palliative care team) were part of a multidisciplinary team approach to end of life care and covered both Friarage and James Cook Hospital. The team provided information to patients and staff, regarding diagnosis and treatment and offered specialist advice on the management of difficult symptoms at the end of life. The SPCT delivered a Monday-Friday 8.30am-4.30pm service, with advice available out of hours and at weekends from the sub-regional (a collaboration of South Tees and North Tees) palliative care consultants. There was one band 7 CNS (clinical nurse specialist) who provided in-reach services to the Friarage Hospital.

The portering services team managed the mortuary at the Friarage Hospital. This came into effect from April 2015 due to lack of service hours required to fund a mortuary technicians post.

There were 1,866 recorded deaths recorded for the trust between April 2015 and March 2016.

When we inspected the trust in December 2014, we rated the safe and effective domains in EOLC as 'requires improvement'. Therefore, this inspection focussed only on these areas and we decided to review the well-led domain to see if leadership, management and governance assurances were in place.

We visited medicine, surgical, respiratory wards and the accident and emergency department, where end of life care could be provided.

We spoke with one relative, and seven staff including the clinical nurse specialist, ward nurses, porters and mortuary staff. We looked at the records of three patients receiving end of life care and five DNACPR forms (do not attempt cardiopulmonary resuscitation).

End of life care

Summary of findings

At the previous inspection in 2014, we rated safe and effective as 'requires improvement'. This was because DNACPR forms were inconsistently completed and patients who were identified as lacking capacity did not always have their mental capacity assessed. It was also found that whilst staff knew how to report incidents they were not always provided with feedback. The assessment of nutrition and hydration had been inconsistent and the National Care of the Dying Audit saw that the trust performed below the England average in terms of the review of patients nutritional and hydration needs. During the previous inspection, there was no evidence of advanced care planning.

At this inspection we saw that the service had made significant improvements and we rated End of Life Care as good overall because:

- There were systems for reporting incidents across the hospital. We saw examples of lessons learnt following audit feedback.
- There were clear, well documented and individualised care of the dying documents and appropriately completed DNACPR forms.
- The culture was open and transparent and encouraged effective communication between the SPCT and ward staff.
- Staff were supported to attend mandatory training and in all areas that we saw were 100% compliant.
- Although there was a clear vision for the service, which specialist palliative care staff had developed, the trust specific strategy for end of life care was in draft and under review and it was not clear when Board approval would be finalised.
- The trust did not have an overall strategic lead for palliative care but this was identified as a future development. There was no action date to implement this role but the Board were keen to ensure that this happened.
- Within the 2015 results of the National Care of the Dying Audit, the trust was above the England average in all five of the clinical indicators but only achieved two of the eight organisational indicators. This was identified as a key area in the work programme for the SPCT in 2016/2017.

However:

- Some equipment in the mortuary was not safe for its intended use.
- Risk assessments for porters and security staff were found to be out of date.
- There was no regular audit programme for infection prevention and control in the mortuary.

End of life care

Are end of life care services safe?

Good

We rated safe as good because:

- There were systems for reporting incidents across the hospital. We saw examples of lessons learnt following audit feedback.
- There were sufficient numbers of trained clinical, nursing and support staff with an appropriate skill mix to ensure that patients receiving end of life care were well cared for.
- Staff were supported to attend mandatory training and in all areas that we saw were 100% compliant.
- There were adult safeguarding procedures in place supported by mandatory staff training. Staff knew how to report and escalate concerns regarding patients who were at risk of neglect and abuse.
- Medications were stored correctly and syringe drivers were used in accordance with National Patient Safety Agency (NPSA) Rapid Response reports.
- Syringe driver monitoring was in place and regular audits showed high levels of document completion.
- Priorities were in place to provide advanced care planning training.
- Nutrition and hydration assessments were now completed as part of the core care plan.

However:

- We saw a hydraulic concealment trolley in the mortuary, which was not safe for its intended use.
- Risk assessments for porters and security staff had not been reviewed since they were originally written in October 2013. These included moving and handling deceased patients and the use of hydraulic equipment.
- Deceased patients were occasionally transferred during the night from wards to the mortuary, which was located outside and across the main car park. There were no written guidelines for this and no agreement as to which staff could access the mortuary during the night. However, we were shown a standard operating procedure which was written during our inspection to mitigate this.
- There was no regular audit programme for infection prevention and control in the mortuary.

Incidents

- Staff understood their responsibilities with regard to reporting incidents and they knew how to report them. They also told us that they received direct feedback relating to incidents.
- Staff told us they were involved in the review of incidents on a trust wide basis if end of life care treatment had been identified. There was weekly contact with the lead SPCT nurse who verbally shared incident information.
- We saw examples of incident investigations where lessons were learnt. For example an incident where a naso gastric tube (a narrow tube passed into the stomach through the nose) checklist was not completed prior to discharge. We saw that a structured plan was devised for the patient and district nurses by the ward and further training was provided to the ward staff.
- Serious incidents relating to palliative care were reviewed by the risk committee and shared with the SPCT directorate. We saw examples of the minutes, which confirmed this.

Duty of Candour

- Duty of candour is a legal duty on NHS trusts to inform and apologise to patients if there had been mistakes in their care, which led to moderate or significant harm.
- Staff we spoke with had an understanding about the duty of candour, they understood their responsibly to be open and transparent. Staff told us that patients and relatives were kept informed when incidents occurred.

Cleanliness, infection control and hygiene

- We visited the wards and found there were infection control and prevention systems in place to keep patients safe with appropriate signage around the wards.
- We visited the mortuary at the Friarage Hospital and found that it was clean. We saw appropriate hand washing facilities were available.
- We saw staff had access to personal protective equipment (PPE), such as gloves and aprons and were seen to be using the equipment and facilities.
- We saw there were hand washbasins, liquid soap, paper towels, hand gels and protective equipment available.
- The training data showed that the SPCT including end of life nursing staff achieved 100% compliance for infection control training, against an internal target of 90%.

End of life care

- We were not able to view the infection control and handwashing audits for the mortuary at the Friarage Hospital. We were told that they were held at the James Cook Hospital. However, the trust later told us that these audits had not been completed.

Environment and equipment

- Staff we spoke to told us that they had no problems accessing equipment for patients at end of life.
- Syringe drivers were available and although there was no central store, staff told us they had no problems in obtaining the syringe drivers they needed.
- The trust followed the guidelines within the NPSA Rapid Response Report: Safer Ambulatory Syringe Drivers (NPSA/2010/RRR019) published in December 2010, which advised that ambulatory syringe drivers should change over to devices with specific safety features. Staff told us that equipment was accessible within a few hours for patients at the end of life who were being discharged using the fast track route.
- We visited the mortuary at the Friarage Hospital and saw a hydraulic concealment trolley, which did not show maximum weight limitations and had not been tested since 2007. There was an additional hydraulic trolley; however, there was some confusion as to the maximum weight limitation for bariatric patients. Staff we spoke to were unclear as to which trolley should be used and when. This issue was brought to the attention of management who chased an order for its replacement immediately.
- The mortuary staff told us that they had not experienced any difficulties involving capacity but they could access the mortuary at the James Cook Hospital if they experienced problems.

Medicines

- There were guidelines on the trust intranet (NHS North of England Cancer Network) for medical staff to follow when prescribing anticipatory medicines. Medical staff we spoke with were aware of the guidance and how to access the SPCT for advice should they need it. The guidelines were in the process of being updated at the time of inspection.
- We looked at the files of three patients Medication Administration Records (MAR's) and we saw they were completed clearly; including administration of medicines prescribed 'as required'.
- We saw that the SPCT in-reach nurse worked closely with ward staff to provide daily advice and support.
- We spoke with staff on the wards, who told us the system was effective and staff were confident patients would receive the appropriate medication even at short notice.
- The SPC in-reach nurse was an advanced practitioner, which enabled her to prescribe medication for patients.

Records

- The SPCT had developed a care plan for the last days of life (core care plan 25), which recorded the care, treatment and wishes of the patient leading up to and at the point of death. We saw these documents were in place and audits completed regularly by the SPCT to ensure that the quality of information was high.
- We viewed five sets of patient records and found that on all occasions these were completed correctly with discussions with the patient and relatives recorded where appropriate.
- We saw that DNACPR records were completed fully and were subject to monthly audits to ensure they were consistently completed.
- The SPCT checked Vital Pac (an electronic system which analyses and monitors patients vital signs) twice each day to proactively check for patients who had been identified as requiring end of life care. We saw from the minutes of the end of life steering group in January 2016 that an additional 110 patients (since August 2015), had been identified who would not previously have been seen.
- The SPCT were moving towards the integration of System1 as a database for patient information. Staff had received a demonstration of the system and work was underway to have the 'agreed template' in place by August 2016. These arrangements would help to keep patients safe as different groups of staff could access the patient's records.
- Information governance training was part of the annual mandatory requirement for all staff. We saw that the SPCT and nursing staff within the end of life team achieved 100% compliance against an internal target of 90%.

Safeguarding

End of life care

- We spoke with staff about safeguarding. Staff were knowledgeable about the trusts safeguarding policies and their role and responsibilities. Staff could give examples of what constituted a safeguarding concern and how they could raise an alert.
- The trust had mandatory safeguarding training programmes in place for staff as part of their initial induction. The training data showed that the SPCT including all end of life nursing staff team achieved 100% compliance for safeguarding adults level 1 and safeguarding children level 1, against an internal target of 90%. They also achieved 100% compliance for safeguarding children level 2. SPCT staff had received the appropriate training levels for their role.

Mandatory training

- Mandatory training was undertaken by all staff providing end of life care. We were provided with training data, which showed that the SPCT and end of life nursing staff achieved 100% compliance in modules such as dignity at work, health and safety, safeguarding and information governance.
- All staff we spoke to advised that it was sometimes difficult to attend training due to the lack of staff cover on the wards. Two ward sisters told us that there was a lack of training around end of life care.
- We spoke with the end of life senior management team, who told us that one of the key priorities for end of life care was to 'formalise an education plan and monitor the impact of training within the service'. We saw a specialist palliative care education plan, which showed the development of a formal education plan for all staff but this did not have an agreed action date for completion.

Assessing and responding to patient risk

- We saw that staff were able to identify risks quickly and manage them positively using the individualised plan of care.
- When a patient was reaching the end of their life, the ward staff would identify this using the Vital Pac system. This would alert the SPCT that the patient might require their services.
- Staff told us about how they assessed a patient and that managing identified risks was part of that process. We saw records in place covering nutrition and hydration.
- Staff on the wards could contact the in-reach SPCT nurse Monday to Friday for a patient referral or telephone advice.
- Ward staff told us the in-reach SPCT nurse had a visible presence on the wards. Any changes to patient's conditions generally instigated a visit by the SPCT. We saw patient's daily notes by nursing, medical and therapy staff with updates on any changes.
- The SPCT in-reach nurse told us that she tried to visit every ward each day to support staff in the management of patients.

Nursing staffing

- We found staffing levels were sufficient to ensure that patients received safe care and treatment.
- The SPCT delivered a Monday to Friday 8.30am-4.30pm service, outside of these hours and at weekends, ward based staff could access specialist support from the sub-regional palliative care consultant.
- Ward staff provided end of life care all the time, with specialist support from SPCT.
- One band 8a lead nurse for end of life care and bereavement managed the team. There was also one band 7 clinical nurse specialist providing in-reach service to the Friarage, and three band 7 CNS's based at James Cook Hospital. Additionally there were two band six palliative care support sisters.
- The end of life team did not use agency staff. There was consistency in support from the SPCT.

Medical Staffing

- There were 1.3 WTE SPC consultants, one full time and one part time doctor, and one specialty doctor covering the community and acute areas (mostly Friarage Hospital). Each provided cross-site cover when needed. This was in line with the best practice guidance for the number of patient deaths. On-call consultants completed a written handover, which was faxed to the next consultant on-call.
- Medical staff we spoke with told us that the SPCT were available for specialist advice as needed.
- There was a sub-regional palliative care consultant on call for advice only, which operated from 5pm-9am on weekdays and 24 hours at weekends and bank holidays.
- Ward staff told us that they would contact the sub regional on-call consultant when required.

Major incident awareness and training

End of life care

- Major incident and winter management plans were in place. Senior staff had access to action plans and we saw that these included managers working clinically as appropriate, staff covering from different areas and prioritisation of patient need.
- Specialist support was available from the SPCT when required.

Are end of life care services effective?

Good

We rated effective as good because:

- Care and treatment was delivered in line with national guidance and best practice outcomes.
- We saw the use of nursing assessment tools within the core care plan, which included the assessment of pain, nutrition and hydration. Additional prompts were in place, which included patient choice, comfort and individual's ability to tolerate food and drink.
- The SPCT consisted of a team of doctors and nurses who were skilled and knowledgeable. They were experienced in providing support and training to other staff and provided training slots in the preceptorship programme.
- The service participated in relevant local and national audits, including clinical audits. Results and service development were discussed and shared at monthly end of life steering group meetings.
- Ward staff worked together with the SPCT and end of life teams to understand and meet the range and complexity of patients' needs. They demonstrated joint working in assessing, planning and delivering end of life care to patients.
- Staff providing end of life care were qualified and had the skills to carry out their roles effectively and in line with best practice.

However:

- Results from the National Care of the Dying Audit 2015 showed that the trust achieved only two of the eight organisational indicators but had scores better than the England average for all clinical indicators. This was identified as a key area in the work programme for the SPCT in 2016/2017.
- The SPCT was not currently staffed or funded to provide a seven day week service although a business case for additional funding had been submitted to the trust commissioners.

Evidence-based care and treatment

- The trust participated in the requirement and implementation of a person centred holistic nursing assessment which was in development at the time of the 2014 inspection and was implemented in January 2015 and included clear assessment of nutritional and hydration needs. The document was created using elements, which worked well from the Liverpool Care Pathway and incorporated existing nursing documentation. This was updated following consultation with ward staff.
- The document contained guidance on appropriate medication for controlling common symptoms at the end of life and daily recording of patient's and family's needs. The document included national guidance from sources such as the Leadership Alliance for the Care of Dying People, the Department of Health End of Life Strategy and the National Institute of Health and Care Excellence (NICE).
- The SPCT delivered 4 hour training slots based on 'One chance to get it Right' as part of the preceptorship programme for nursing staff and junior doctors. There were also designated educational sessions for medical staff. The Leadership Alliance developed this approach for the Care Of the Dying Patient (LACDP 2014). It focused on the needs and wishes of the dying person and those closest to them, in both the planning and delivery of care wherever that may be.

Pain relief

- Palliative medicines (which can alleviate the pain and symptoms associated with end of life) were available at all times. Anticipatory medicines were managed appropriately.
- We saw pain assessments in place as part of the core care plan. We looked at the records of three patients and saw that patients were assessed and reviewed regularly.
- Staff told us they could contact the SPCT for advice about appropriate pain relief if required.
- A relative told us 'the nurse's came straight away when my husband was in pain'.

End of life care

- Appropriate medication was available in the ward areas, and there were examples that anticipatory prescribing was being managed.

Nutrition and hydration

- We saw that patients had been assessed using a Malnutrition Universal Screening Tool (MUST), which identified nutritional risks. Records showed monitoring charts were completed for food and drink taken. Specialist dietician support was available on all wards and we saw records of their involvement.
- End of life care staff told us as part of initial assessment; nutrition and hydration needs at the end of life were assessed. Patient choice and comfort were included in the prompts for staff to make decisions in the best interests of patients without the mental capacity to make their own decisions. The care plan we saw recorded this.
- Staff told us that those patients identified as being in the last hours or days of life had their nutrition and hydration needs evaluated and appropriate actions followed.
- We saw monthly audits completed by the SPCT, which included documentation checks regarding nutrition and hydration assessments.

Patient outcomes

- The trust participated in the National Care Of the Dying (NCDAH) audit 2015. The results were published in April 2016. The trust was above the England average in all five of the clinical indicators but only achieved two of the eight organisational indicators.
- We viewed audit results of the 'care of the dying patient' documentation checks. This audit also incorporated DNACPR audits. Audit results were mixed with some aspects of the documentation completed to a consistently high standard. For example, DNACPR completion achieved 94% compliance in February 2016. Preferred place of death recording dropped to 50% compliance in January 2016 but increased to 78% in February 2016. Data was not captured to show where a patient actually died compared to their requested place of death.
- Hydration and nutrition assessment was audited every month. February 2016 showed 78% compliance (hydration) and 86% (nutrition) compliance. All patient documents we audited at the time of inspection were found to be fully completed.
- Syringe driver monitoring charts were audited each month and showed 67% compliance in February 2016. This was a lower figure than January, where 100% compliance was achieved.

Competent staff

- Plans were in place to deliver a formalised education programme for end of life. We saw the SPCT education plan for 2016 but there were no completion dates to achieve the final plan. Within the education directory, a plan was in place to produce a leaflet to inform professionals of how to access education. The nurse leading the development of this leaflet told us that there were some funding difficulties, which had delayed its development.
- Staff told us they had received an annual appraisal and compliance figures showed 100% for all end of life staff. We saw however that in 10 porter's files that we checked, all were overdue with their appraisal.
- SPCT staff told us they had recently accepted student nurses to shadow the team.
- The SPCT delivered training to staff as part of their preceptorship period. Four hourly slots were delivered twice a year.
- The SPCT provided education on a formal and informal basis, which included delivery to staff from external organisations, including those working in local nursing homes.
- All ward staff we spoke to told us that it was difficult to release staff to attend training.
- Link nurses had been identified for most wards with an emphasis on medical wards. We spoke with two sisters on the wards who told us that training for end of life care had 'dried up' and it was felt that formalised training sessions were needed.
- We saw that the trust had recently held an end of life conference, which was part of the dying matters week.
- The end of life care steering group had agreed to make all forms of advance care planning a priority for the 2016-18.

Multidisciplinary working

- The palliative care team had established positive working relationships with community services, including GPs, district nurses and the community palliative care team at the local hospice.

End of life care

- The SPCT worked in a collaborative and multidisciplinary manner. We observed a weekly multidisciplinary meeting, which included discussions regarding the development of care and treatment plans for patients.
- The service included spiritual support from the chaplaincy team and bereavement support from the bereavement centre.
- The SPCT told us they benefited from good working relationships with staff at the hospital and in the community. For example, there were opportunities to attend ward meetings.

Seven-day services

- The SPCT was not currently staffed to provide a seven day a week service. The service was available Monday to Friday 8.30am-4.30pm.
- We saw within the end of life steering group minutes that there had been discussion around the provision of seven-day specialist care service. The senior management team told us that the development of this service was subject to funding and consultant recruitment.
- We spoke with the lead nurse who told us there was a business case in place to provide a seven-day direct service from the SPCT.
- All staff told us without exception they felt it would benefit patient care if there were a seven-day SPCT service.

Access to information

- We looked at the records of three patients identified by end of life. We spoke with staff who confirmed risk assessments were available and staff had all of the information they needed to deliver effective care in a timely way.
- We saw documentation available for staff to record patient's decisions around advance decisions, spiritual needs and hydration, which was integral to the core care plan.
- We saw guidance documentation (information booklet) produced by the SPCT that could be accessed by ward staff.
- If a patient was going home at end of life then the GP was informed by telephone handover from the discharging medical team and out of hours services using a faxed form. If the SPCT have been involved, there would also be a discharge letter in addition to an e-discharge notification.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a policy in place regarding consent, which was in line with Department of Health guidelines.
- Mental capacity act training was part of the annual mandatory requirement for all staff. We saw that the SPCT and nursing staff within the end of life team achieved 100% compliance against an internal target of 90%.
- Staff we spoke with all had confidence of their understanding of the mental capacity act and deprivation of liberty safeguards.
- We viewed assessment documents for patients identified as being at end of life. We saw guidance for staff to follow in relation to best interest decisions for patients who did not have capacity to make decisions about care and treatment.
- We viewed five DNACPR forms. We saw one example of a patient who did not have the capacity to be involved in discussions about the situation. We saw positive evidence of assessments being completed with their lack of capacity clearly recorded. We saw that the decision had been discussed with the patient's relatives and that the decision had been recorded.
- The results of the DNACPR audit in January 2016 showed only 54% compliance in relation to correct form completion. Within this figure, 30% of files did not show if an emergency health care plan was in place. 90% were signed by a consultant and 100% compliance was achieved in relation to the completion of mental capacity assessments.
- We saw evidence of the SPCT addressing DNACPR document completion and improvements made following consultation with ward staff and clinicians. We saw regular audits for DNACPR to ensure compliance.

Are end of life care services well-led?

Good

We rated well-led as good because:

End of life care

- There were arrangements for monitoring the quality of services. Governance processes gave assurance that systems were regularly reviewed and improvement made. A 2016/2017 SPCT work programme measured progress against key quality performance indicators.
- There was positive leadership at a local level. Service leaders were visible and approachable. Staff were proud of the care they were able to give and received positive feedback from patients and families.
- There was effective communication both written and verbal between the SPCT and ward nurses in relation to patient care.
- There were examples of patient engagement including a review of EOLC for patients with learning disabilities.

However:

- Although there was a clear vision for the service, which specialist palliative care staff had developed, the trust specific strategy for end of life care was in draft and under review and it was not clear when Board approval would be finalised.
- The trust did not have an overall strategic lead for palliative care but this was identified as a future development. There was no action date to implement this role but the Board were keen to ensure that this happened.

Vision and strategy for this service

- A palliative care strategy development paper was completed in November 2015, which identified a clear vision for the service. The key areas were: to progress to a proactive, 7-day, well-staffed, clinical service integrated across acute/community care settings, delivering needs-based equitable palliative and end of life care regardless of diagnosis or prognosis; a single IT system, carer and referrer feedback through partnership working, and delivering an educational programme with involvement in collaborative research. Minutes of the SPCT meetings showed that strategic priorities were being discussed locally, however, the trust specific strategy for end of life care was in draft and it was not clear when it would receive Board approval.
- The service participated in the Ambitions for Palliative and End of Life Care: a National framework for local action 2015-2020, published September 2015 by the National Palliative and End of Life Care Partnership. Locally the trust's end of life steering group work programme update provided some indication of progress against ambitions arising from some key drivers.

Governance, risk management and quality measurement

- The specialist palliative care team met every month to discuss governance issues. The end of life steering group met every other month to look at clinical issues such as audits, patient feedback, risk, training and work programme reviews.
- Staff told us they were informed verbally of any areas of improvement, for example, DNACPR audit results, during monthly ward meetings and SPCT ward visits.
- The specialist palliative care directorate meetings included a matrons briefing however we saw that matrons were not always available to participate in these discussions each month.
- The SPCT held a weekly MDT meeting to share risks, care and treatment plans for those patients who had been identified as requiring end of life care.
- Patient safety and quality were addressed at a senior management level within the risk management group meetings. We saw examples of investigation reports and learning. This meeting enabled a holistic understanding of performance as safety and quality activity was integrated.
- There was a 2016/2017 work programme for specialist palliative care MDT. This included audit and service improvement.

Leadership of service

- There was a non-executive lead for end of life care at trust board level.
- There was a newly appointed medical director for community care centre, which included palliative care following the trusts re-structure in April 2016.
- The trust did not have an overall strategic lead for palliative care but this was identified as a future development. There was no action date to implement this role but the Board were keen to ensure that this happened. An option was for the strategic lead for end of life care to come from the specialties of respiratory or cardiology. The clinical lead for palliative care felt this would be a positive move and would reinforce the end of life care agenda beyond cancer/oncology.

End of life care

- We saw positive local leadership within the SPCT. The team were visible and we received positive comments from ward areas.

Culture within the service

- Staff at ward level told us end of life care delivery was part of their daily role. They spoke positively of the involvement of the SPCT and their involvement was essential.
- Staff on wards and departments spoke passionately about the end of life care they provided. All teams worked in collaboration, to meet the needs of patients.
- Staff shared their views about the service openly and constructively. They were caring and passionate about the hospital and about the care, they provided to patients.
- All staff we spoke with could provide examples of how the patient's needs was at the centre of the end of life care being delivered and offered.
- There was a general feeling of 'openness and honesty' and staff told us they would ask senior staff for advice if they needed it.

Public engagement

- There was information displayed throughout the public areas regarding the Patient Advice and Liaison Service (PALS).
- The trust had a patient / carer group, which met several times a year and assisted in the design and development of the Patient information booklet for the hospital.
- The trust took part in a bereaved relative's survey. The survey took place over a 6-month period commencing in October 2015. There were 34 responses across both hospitals and all directorates. The majority of which were positive. Results showed 91% of responses said they felt involved as much as they wanted in their relative or friends care, 95% said they had the opportunity to ask questions and 6% of responses said that they were not given information on what to do following death.
- The palliative care consultants had presented information to groups in the trusts geographical area. These included training sessions and awareness meetings to GPs and local care homes.
- The trust held an end of life care conference in May 2016, which was part of the dying matters week.

Staff engagement

- We observed the SPCT team meeting. All service staff, except community, attended this. We saw the meeting gave the opportunity for all members of staff to raise items on the agenda. Additionally, every member of staff felt confident to raise issues that were relevant to their role or they could add value to the discussion.
- Staff in the SPCT told us they attended matrons meetings as 'often as possible'. There was evidence of shared knowledge regarding patient treatment plans. We saw effective communication both written and verbal between the SPCT and ward nurses in relation to patient care.
- We saw effective communication both written and verbal between the SPCT and ward nurses in relation to patient care.

Innovation, improvement and sustainability

- The SPCT pro-actively identified patients who were at the end of life. This was to review as many patients at end of life as possible. The patients were identified on the Vital Pac system and when their status altered to 'end of life' the SPCT were able to add them to the referral list. Since this service was developed in September 2015, the team have reviewed over 300 patients who would not otherwise have been seen. This allowed symptoms to be reviewed, documentation to be prompted as well as giving the ward staff support in caring for patients at end of life. It had also given families the opportunity to ask questions and be given the time and support they need.
- The audit process within end of life had been updated to reflect the changes in the core care plan. Following the last CQC inspection, an audit was completed each month, which included aspects of end of life care.
- The trust worked closely with local care homes in relation to shared advanced planning documentation.
- Following a conference held as part of the dying matters week, the Lead Nurse for End of Life Care was now leading on a regional piece of work for the South Tees looking at embedding and standardising education around the deciding right tools within the locality.
- South Tees had been given the opportunity to work with Southampton University to do action research. The focus was acute patients reaching end of life and the practicalities that families face. The pilot will run until September 2016.

Outpatients and diagnostic imaging

Safe	Good
Effective	Not sufficient evidence to rate
Overall	Good

Information about the service

The Friarage Hospital in Northallerton, North Yorkshire was one of two acute hospitals forming South Tees Hospitals NHS Foundation Trust. It served a rural population of 122,000 people.

It served an area of 1,000 square miles extending from the North Yorkshire moors to the central Pennines, the borders of York district in the south and the borders of Darlington in the north.

The Friarage outpatients department were situated on the main Friarage site in Northallerton. There were 120,408 outpatient appointments between September 2014 and August 2015. Outpatient clinics were held in two different locations on the site: the main outpatients; and the Scott Suite.

Within the main outpatients department, there were 20 consulting rooms. The outpatients department ran a wide range of clinics, across a large number of specialties such as urology, gynaecology, orthopaedics, general surgery, breast surgery, orthodontics, ophthalmology, ear, nose and throat (ENT), respiratory medicine and neurology. The imaging services were conducted from one location on the site and provided general radiography, computerised tomography (CT) scans, breast imaging, ultrasound scanning and fluoroscopy.

The trust was previously inspected in December 2014 where Outpatients and Diagnostics at the Friarage Hospital was rated as 'good' in effective, caring, responsive and well-led. The safe domain was rated as 'requires improvement'. This inspection focussed solely on the safe domain.

During our inspection, we visited the Outpatients Department at the Friarage. We observed care and staff working. We spoke with six members of staff (including, managers, nursing staff and health care assistants). We spoke with seven patients. We reviewed six sets of care records and prescription charts.

Outpatients and diagnostic imaging

Summary of findings

At our last inspection in December 2014 we identified that resuscitation equipment in outpatients and diagnostic imaging areas was not checked in accordance with trust policies and procedures, and there were no mechanisms in place for reviewing and updating patient information.

At this inspection, the department was rated as safe because:

- The departments were clean and hygiene standards were good.
- They had enough personal protective equipment in all the areas we inspected and staff knew how to dispose of items safely and within guidelines.
- Staff ensured equipment was clean and well maintained, so patients received the treatment they needed safely. Safety checks were completed.
- Medicines were safely stored in accordance with policy. Outpatients and diagnostic imaging used early warning scores to monitor and manage patient risk.

Are outpatient and diagnostic imaging services safe?

Good

We rated safe as good because:

- Incidents were reported using an electronic reporting system and all staff we spoke with knew how to report incidents using the system if they needed to. Incidents were investigated and 'lessons learned' were shared with staff.
- The level of care and treatment delivered by the outpatients and diagnostic imaging services was good.
- The service prioritised patient protection from avoidable harm and abuse. There were clearly defined and embedded systems, processes and standard operating procedures to keep people safe and safeguarded from abuse.
- Resuscitation equipment in outpatients and diagnostic imaging areas were checked in accordance with trust policies and procedures and was monitored daily.
- Staff were aware of duty of candour process and practice together with their responsibilities.
- Medicines were safely stored in accordance with policy. Fridge temperatures were checked on a daily basis however we found the room temperatures where medication was stored was not recorded.

Incidents

- The departments had systems to report and learn from incidents and to reduce the risk of harm to patients.
- The trust used an electronic system to record incidents and near misses. Staff we spoke with had a good working knowledge of the system and said they could access the system and knew how to report incidents. Staff were able to give examples of incidents that had occurred and investigations that had resulted in positive changes in practice.
- The outpatient and diagnostics department across the whole trust had reported three serious incidents from the period April 2015 to March 2016. These related to a fall, a diagnostic incident including delay and a screening issue.

Outpatients and diagnostic imaging

- Managers told us that the incident reporting procedures allowed staff at all levels and across multidisciplinary teams to reflect on practice. The matron gave feedback in monthly safety briefing meetings to all staff.
- Staff confirmed they receive feedback sometimes from submitted incident reports on an individual basis and at team meetings.
- Staff had a clear understanding of the duty of candour and were aware of their responsibilities to be open, honest and inform patients (and their families).

Cleanliness, infection control and hygiene

- Domestic services staff carried out daily and weekly cleaning regimes.
- Handwashing signage and handwashing facilities were situated at the entrance of the Outpatients Department. Antibacterial hand gel dispensers were also available at various locations within each unit. There were infection prevention and control (IPC) posters and information on display with many being designed by children to promote good IPC practice. We observed staff and visitors washing their hands and using hand gel.
- Personal protective equipment (PPE) such as gloves and aprons was used appropriately and available for use throughout the departments. Once used it was disposed of safely and correctly. We observed staff when treating patients wore PPE.
- The outpatient's department matron carried out regular hand hygiene, clean equipment, standard precautions, and uniform policy checks. They measured compliance and results showed 100%.
- Patient waiting areas and private changing rooms were clean and tidy. Single sex and disabled toilet facilities were available and these areas were at an acceptable standard.

Environment and equipment

- Staff ensured that consulting, treatment and testing rooms were well stocked.
- At the Friarage each outpatient clinic was situated in different compartments. Staff told us the layout of the department was not ideal and meant they were constantly doubling back on themselves.
- At our last inspection in December 2014, we identified concerns that resuscitation equipment had not been regularly checked in accordance with the trust's policies. We found at this inspection, resuscitation trolleys for adults and equipment including suction and oxygen lines were checked daily and checklists were signed.
- The reception area was situated at the entrance of the department and congestion built up at busy times. We did find there was sufficient seating in the clinical areas and chairs were in reasonable condition.
- We saw, and staff confirmed that, there was sufficient equipment to meet the needs of patients within the outpatients and diagnostic imaging departments. Staff told us that they were encouraged by senior management to raise any immediate concerns to ensure they were resolved quickly or escalated to the appropriate department manager.
- Managers told us that capacity had reached its limit in terms of the number of clinics that could take place each session.

Diagnostic Imaging:

- The design of the environment within diagnostic imaging kept people safe. There were radiation-warning signs outside any areas that were used for diagnostic imaging. Imaging treatment room no entry signs were clearly visible and in use throughout the departments at the time of our inspection.
- During our observations, we saw that there was clear and appropriate signage regarding radiological hazards in the diagnostic imaging department.
- Staff wore dosimeters and lead aprons in diagnostic imaging areas to ensure that they were not exposed to high levels of radiation and RPAs carried out dosimeter audits to collate and check results. Results were all within the acceptable range.
- In diagnostic imaging, quality assurance (QA) checks were in place for equipment. These were mandatory checks based on the ionising regulations 1999 and the ionising radiation (medical exposure) regulations IR(ME)R 2000. These protected patients against unnecessary exposure to harmful radiation.

Medicines

- The trust had a policy for the administration and storage of medicines and staff we spoke with followed this policy.
- We checked the storage and management of medicines and found effective systems in place. No controlled drugs were stored in the main outpatients departments.

Small supplies of regularly prescribed medicines were stored in locked cupboards and where appropriate, locked fridges. We saw the record charts for the fridges, which showed that staff carried out temperature checks daily and that temperatures were maintained within the acceptable range. All medicines we checked were in date.

- Medicines management training was provided for registered nurses across the outpatients and diagnostic imaging departments.
- In the diagnostic imaging and breast screening departments, some interventional procedures required sedation and pain relief and these included controlled drugs.

Records

- Records in the outpatient department were a mixture of paper based and electronic. Diagnostic imaging department records were digitised and available for clinicians across the trust.
- Records contained patient-specific information relating to the patient's previous medical history, presenting condition, demographic information and medical, nursing, and allied healthcare professional interventions.
- Staff managed records and their preparation for clinics. Referral letters and discharge summaries were stored electronically and provided back up when patient's notes were unavailable. Staff said that a patient would always be seen as long as there was some information about them available and they could create temporary notes for the episode, which they merged with main records when available.
- Records were stored securely at outpatient's reception and were carried to and from the clinic areas by trust volunteers as patients checked in. They were then stored in lockable drawers at each clinic suite. These ensured records were safe and confidential until the point of need.
- We reviewed seven patient records, which were completed with no omissions. Nurses carried out assessments of blood pressure, weight, height, and pulse for patients according to clinical requirements. We observed staff undertaking these checks during our inspection.
- Outpatients and diagnostic imaging staff completed risk assessments including early warning score (EWS), pre-assessment for procedures and pain assessments. These were recorded appropriately in patient records and nurses escalated any concerns to medical staff in clinics.

Safeguarding

- All staff we spoke with were aware of safeguarding policies and procedures and knew how to report a concern. They knew that support was available if they needed it or they had a query.
- There was a designated safeguarding lead for the outpatients department.
- Information provided by the trust showed that 100% of applicable staff in outpatients and 100% in diagnostic imaging had undergone safeguarding adults level 1 and safeguarding level 2 training as part of their mandatory training.

Mandatory training

- Staff were given sufficient time to attend training and more on-site training was being organised to ensure that staff and service needs were being met.
- The Core 7 mandatory training package included: basic life support, blood transfusion, conflict resolution, dignity at work, fire safety, health and safety and patient well-being, Infection prevention and control, information governance, manual handling, mental capacity act, safeguarding level 1 and 2 for vulnerable children and adults. Data showed the majority of staff had completed mandatory training or were scheduled to complete the modules by the end of the year.
- Department managers told us that staff were allowed sufficient time to attend mandatory training.

Assessing and responding to patient risk

- Staff were aware of actions to take if a patient's condition deteriorated while in each department and explained how they could call for help, access the paediatric and adult cardiac arrest teams and the process for transferring a patient to the Accident and Emergency Department. There were also a number of resuscitation trolleys and defibrillators across outpatients and diagnostic imaging departments, which were available.
- The radiation protection policy and procedures in the diagnostic imaging department ensured that roles and

responsibilities of all staff including clinical leads, medical physics expert and specialist safety advisor were clear and that the risks to patients from exposure to harmful substances were managed and minimised.

- Diagnostic imaging policies and procedures were written in line with the Ionising Radiation (Medical Exposure) 2000 regulations. IR(ME)R and the most recent medical physics expert report from September 2015 made recommendations regarding the commissioning of new x-ray and CT equipment, improved audit response times for investigation of incidents and a full trust review of IR(ME)R and employer procedures. There were plans in place to address all of these recommendations with full and on-going support of the RPA.
- Named and certified radiation protection supervisors (RPS) provided advice when needed to ensure patient safety at all times. The trust had radiation protection supervisors (and liaised with the radiation protection advisor (RPA)).
- Arrangements were in place for radiation risks and incidents defined within the comprehensive local rules. Local rules are the way diagnostics and diagnostic imaging work to national guidance and vary depending on the setting. Policies and processes were in place to identify and deal with risks. This was in accordance with IR(ME)R 2000.
- Staff asked patients if they were or may be pregnant in the privacy of the x-ray room therefore preserving the privacy and dignity of the patient. This was in accordance with the radiation protection requirements and identified risks to an unborn foetus. We saw different procedures were in place for patients who were pregnant and those who were not. For example, patients who were pregnant underwent extra checks.
- Outpatients and diagnostic imaging used early warning scores to monitor and manage patient risk. Nursing staff assessed patients and gave scores to direct management and treatment of patients.

Nursing and allied health professional staffing

- A mixture of registered nurses and healthcare assistants staffed the outpatients department. At the time of our inspection, the department had one 0.8 whole time equivalent (WTE) manager, 2.1 WTE registered nurses, 14 band 2 healthcare assistants, two band 3 healthcare assistants, one band 1 healthcare assistant and 0.8 WTE plaster technicians.
- Within the imaging department, there were 14.8 WTE radiographers employed and 4.2 WTE healthcare assistants.
- All department managers told us that staff were flexible to be able to ensure cover was available.
- Managers told us they were able to adjust the number of staff covering clinics to accommodate those that were busy or where patients had greater needs. Managers managed rotas based upon activity within the departments.
- There was liaison across outpatient's services and across sites for staffing with areas supporting each other where possible.
- Managers told us they monitored staff sickness and rates in outpatients were consistently very low.

Medical staffing

- Medical staffing was provided to the outpatient department by the various specialties, which ran clinics. Medical staff undertaking clinics were of all grades.
- Staff told us that there was only limited use of locums within the outpatient clinics.
- Within the imaging department, some radiologists worked specifically at the Friarage, while others worked across the trust, providing the required radiological cover for each site. There was sufficient medical staff cover to meet patients' needs.

Major incident awareness and training

- There was a major incident policy and staff were aware of their roles in the case of an incident. Outpatients and diagnostic imaging staff participated in table top exercises and events to test the major incident plan.
- There were business continuity plans to make sure that specific departments were able to continue to provide the best and safest service in the case of a major incident. Staff were aware of these and able to explain how they put them into practice.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Outstanding practice and areas for improvement

Outstanding practice

- The trust was developing a detailed programme around patient pathways/flow/out of hospital models. This included developing a detailed admission avoidance model to establish pilot schemes in acute, mental health, community and primary care services. This would ensure patients were virtually triaged earlier in their pathway rather than being admitted to A&E. This would support patients closer to home and in more appropriate facilities, and reserve acute capacity for patients who required it.
- The Lead Nurse for End of Life Care was leading on a regional piece of work for the South Tees locality looking at embedding and standardising education around the 'Deciding Right' tools (a northeast initiative for making care decisions in advance).

Areas for improvement

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

- Ensure that processes are in place and understood by mortuary staff at the Friarage Hospital for the maintenance, moving and handling of equipment and transfer of deceased patients particularly out of hours.
- Continue to review the level and frequency of support provided by pharmacists and pharmacy technicians to ensure consistency across wards.
- Ensure that the end of life strategy is approved and implemented and move to develop a seven-day palliative care service.
- Review arrangements for the discharge lounge at the Friarge Hospital in terms of maintaining and cleaning equipment and ensuring the environment was suitable for patients and purpose.