

# Great Western Hospitals NHS Foundation Trust

## Great Western Hospital

### Quality Report

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

### Ratings

#### Overall rating for this hospital

Requires improvement



Urgent and emergency services

Requires improvement



Medical care (including older people's care)

Requires improvement



Surgery

Requires improvement



Critical care

Requires improvement



Maternity and gynaecology

Good



Services for children and young people

Requires improvement



End of life care

Good



Outpatients and diagnostic imaging

Requires improvement



# Summary of findings

## Letter from the Chief Inspector of Hospitals

Great Western Hospitals NHS Foundation Trust consists of one acute hospital (Great Western Hospital) and four community hospitals, of which three provide inpatient services. There are a total of 450 acute beds (including 12 critical care beds and 38 maternity beds) at the Great Western Hospital. Chippenham Hospital has 37 beds spread over two wards, there is one ward of 25 beds at Warminster Hospital and one ward of 26 beds at Savernake Hospital. The trust provides acute and community healthcare services to a population of around 480,000 people from Wiltshire and the surrounding areas.

Overall, Great Western Hospitals NHS Foundation Trust was rated as requiring improvement. We rated it as good for caring and as requiring improvements in safety, effectiveness, being responsive to patients' needs and being well-led. Maternity and gynaecology services and end of life care were rated as good overall with all other core services rated as requiring improvement. We rated safety within urgent and emergency care as inadequate. Three of the four community services inspected were rated as good in all domains. We rated the children and young people's services within the community as outstanding.

Our key findings were as follows:

### Safety

- Patients were not consistently protected from avoidable harm. Safety was inadequate in urgent and emergency services, and required improvement in all other services except end of life care where we rated it as good.
- Capacity and overcrowding presented significant challenges in the emergency department, which resulted in patients not always been cared for in the most appropriate part of the department.
- Risks to patients were not always appropriately assessed and their safety monitored and maintained. Self-presenting patients in the emergency department did not always receive prompt initial assessment (triage). In inpatient areas, risk assessment tools for identifying risks of thrombosis, pressure damage, moving and handling, nutritional and falls were not consistently completed. Patient observations were not consistently undertaken with the required frequency to ensure that any deterioration in a patient's condition was identified.
- There were shortfalls in the levels of nursing staff across the hospital. There were high numbers of vacancies in some areas and although bank and agency staff were used, not all shifts were covered to provide a full cohort of staff. This was of particular concern in the emergency department where the staffing levels did not take into account the need to care for patients who queued in the corridor or sub waiting room. Also, the level and skill of staff working the children's emergency area and the observation unit were not appropriate at all times.
- The number and grade of medical staff at the trust was comparable with the national average.
- The location, design and layout of the emergency department observation unit was not suitable for the care of patients with mental health needs who presented challenging behaviour or were at risk of harming themselves and/or others.
- Staff were aware of how to report incidents but there were times when they were too busy to do so and they were not always reporting near misses. Situations such as staff shortages and waiting times had become normal and staff did not always complete incident forms in these circumstances. The trust reported a lower number of incidents per 100 admissions compared to the England average.
- Learning from incidents was not taking place in all areas, nor were the benefits of learning from serious incidents being shared in all areas or across the hospital.

# Summary of findings

- There were areas of concern with infection control practices. Although overall the environment was clean and tidy there were some exceptions to this. In the dermatology department there was dust and debris on high surfaces. In the day surgery unit there was debris on the floor and the female toilet was unclean, and in the critical care unit there was dried staining on beds and a commode. Staff were not consistently adhering to good hand hygiene practices or using protective personal clothing such as aprons and gloves when required. There had been 12 reported cases of *Clostridium difficile* up to the end of July 2015, therefore the trust was at risk of breaching its annual trajectory of 20 for the 2015/16 year.
- The management of patients with mental health issues was not fully considered. For patients with a high risk of attempting suicide consideration of ligature risks on the ward were not recorded.
- There was considerable variety in the quality of patient's records in the medical wards. The records were not fully completed nor did they provide detailed information for staff regarding the care and treatment needs of patients.
- Not all areas of the premises were safe and secure, with possible access to confidential records.
- Equipment was not always appropriately and safely stored. Some equipment was also becoming unreliable or outdated, such as the decontamination and sterilisation equipment and equipment for measuring patient's visual fields. Not all maintenance checks were in date.
- Chemicals and substances that are hazardous to health (COSHH) were observed in areas that were not locked and therefore accessible to patients and visitors to the wards. Cleaning materials including chlorine tablets were in the sluices, which were unlocked.
- Sharps bins were in place throughout the medical wards and departments for the safe disposal of used needles and other sharp equipment. However, we observed these were not used in accordance with manufacturer's guidance as they were not consistently closed when in use and some were over two thirds full and still being used. This meant staff were at risk of a needle stick injury.
- Medicines were not always appropriately managed with weaknesses in safe and secure storage, and medicine reconciliations had not been achieved in line with guidance or trust policy.
- The hospital was not meeting the trust target of 80% of staff receiving mandatory training; therefore we were not assured that staff were up to date with safe systems, processes and practices.
- Staff understood their responsibilities and were aware of the safeguarding policies and procedures and the processes for reporting suspected abuse.
- The trust had a major incident and business continuity plan in place. The majority of staff were aware of their roles and responsibilities should the plan be activated.

## Effective

- In most services, people's needs were assessed and care and treatment delivered in line with legislation, standards and evidence-based guidance.
- Information about patient outcomes was collected and monitored, with the trust participating in a number of national audits so it could benchmark its practice and performance against that of other trusts. Although action plans were available for the majority of areas where improvement was required, these were frequently incomplete so progress could not be assured.
- Patient's pain was generally assessed and well managed. The exception to this was in the emergency department, where not all patients had a pain score recorded and not all patients consistently received prompt pain relief. Also in medicine the tools used to measure and monitor pain relief were minimal and did not include ways to support patients with communication difficulties.

# Summary of findings

- Patients had access to adequate food and drinks. However, in the critical care unit a shortage of dieticians and speech and language therapists meant that some patients nutritional, swallowing and communications needs were not always responded to promptly.
- Staff had access to training in order to maintain their skills, however sometimes it was difficult for them to access this due to staff shortages. Not all staff were receiving annual appraisals and supervision was under developed.
- Multidisciplinary working was evident throughout the hospital.
- Access to emergency care and clinical investigations was available across the whole week. The pharmacy service was open for limited hours on a Saturday and Sunday with an on call service outside of these hours. Some on-call cover was provided at weekends by allied health care professionals, although occupational therapists, speech and language therapists and dieticians worked Monday to Friday. The palliative care team was available from 9am to 5pm Monday to Friday, with access to a 24 hour advice line provide by the local hospice.
- Consent to care was not consistently obtained in line with legislation and guidance including the Mental Health Act. In urgent and emergency care there was a lack of records of verbal or informal consent, and it was noted that only 62% of medical staff had received training on consent and the Mental Capacity Act. In medicine patients mental capacity had not been assessed and recorded where appropriate and it was not clear how best interest decisions had been made. Deprivation of Liberty Safeguards were not monitored and had expired without staff being aware, this increased the risk of patients having their liberty restricted without the appropriate safeguards in place.

## Caring

- Staff were providing kind and compassionate care and treated patients with dignity and respect. We rated it as good in all areas inspected.
- Overall patients understood and were involved in their care and treatment. The exception to this was in the medical wards where many patients did not know the plan for their care and treatment and felt communication relating to this was poor.
- Emotional support was available through the chaplaincy service, specialist staff and the volunteers who spent time sitting and chatting with patients.

## Responsive

- Bed occupancy was constantly over 92%, which is above the England average of 85.9% and above the 85% level at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients and the orderly running of the hospital.
- Services were not always organised and delivered so that patients received the right treatments at the right times. The emergency department did not consistently meet waiting time targets. Some patients experienced long waits and there were frequent delays for patients who required admission because there were insufficient beds available in the hospital. At busy times the emergency department was overcrowded and patients queued in the corridor.
- The emergency department observation unit frequently accommodated patients requiring a medical or surgical specialty bed when no suitable bed was available. These patients were not always clinically appropriate for this type of ward. The inappropriate use of the observation unit also meant that the ward was not being utilised effectively for maintaining patient flow within the emergency department.
- Patients with mental health needs were not always assessed promptly by a mental health practitioner within the emergency department, often spending too long on the observation unit, which was not a suitable therapeutic environment for their potentially distraught, agitated or suicidal states.

# Summary of findings

- Premises and facilities were not always fit for purpose. Some accommodation within the emergency department was cramped and was not conducive to the exchange of confidential information.
- Some patients experienced delays in discharge and were unable to leave hospital when they were medically fit. A discharge team were in operation within the hospital working towards improving the discharge process for patients with complex needs. Difficulties in accessing packages of care in the community were delaying patient flow through the hospital.
- The day surgery unit was used to accommodate patients overnight. This area did not meet many patient needs or provide basic facilities.
- The hospital was not meeting the referral to treatment targets for any surgical specialties with the exception of ophthalmology. Whilst some waiting times were reducing, others were getting longer. Average waiting times were worse than those in the South of England NHS Commissioning area.
- Cancelled operations were below (better than) the England average. There was an excellent pre-operative assessment service, a good theatre admissions lounge and discharge facilities, although these were sometimes crowded with people waiting for medicines and transport.
- Staff supported people with learning disabilities to improve their experience of coming to hospital. Staff were kind and patient with people with dementia, but there were few facilities on the surgical wards, such as easy to read signage and dining areas to help frail confused patients.
- There was limited evidence to show how complaints were being used to provide learning and produce changes to improve care and patient experience, with the exception of the maternity service.
- Delays and cancellations as a result of bed unavailability in the critical care unit were minimal.
- Access to the maternity service was efficient and responsive to the local population. Access and flow through the gynaecology inpatient service was affected by in response to intense trust wide service pressures.
- The trust had involvement from other local services and organisations in the planning of meeting the needs for end of life care across the community and were continually looking at ways to work together to provide a co-ordinated service.
- The end of life service was flexible and provided choice and accommodated individual needs for patient and carers.
- Waiting times varied within the outpatients departments. There was no data collected on the percentage of patients waiting over 30 minutes to see a clinician.
- There were challenges in meeting national performance indicators with some breaches in performance. There were backlogs in ophthalmology, dermatology and rheumatology and some delays in diagnostic imaging. Action to address this was not always timely

## Well Led

- Improvement initiatives within the emergency department had been developed, although staff had not been engaged with this process or changes in service provision. These initiatives were in their infancy and their success had yet to be evaluated.
- Within the emergency department improvements were reactive and largely in response to recommendations from external bodies; they were not part of a well-developed strategy or vision for the future. There was limited evidence to show that patients' views were being captured or acted on.

# Summary of findings

- Risks to patient safety and quality within the emergency department were not fully captured in the service risk register and we could not be assured risks were regularly discussed, reviewed and escalated. Risks identified as a result of serious incidents were not always dealt with in a timely way.
- Audits were not consistently used to drive service improvement in the emergency department.
- Staff in the emergency department were committed and highly motivated. They worked well as a team and were well supported by their immediate managers although did not always feel engaged or empowered. Managers were visible, accessible and supportive within the emergency department.
- The effectiveness of the divisional governance systems was not evident in some areas. Areas of concern had not always been identified and actioned. There was limited evidence of learning, change and improvement. There were a number of departmental meetings held, but in some areas it was unclear if and how these fed into the overall clinical governance and provided board assurance.
- There was no governance structure in the critical care unit, with nobody leading on governance in the consultant team. Multi-professional clinical governance meeting were not held monthly and meeting minutes had not been regularly kept. Actions arising from meetings were not monitored effectively. There were limited examples of regular care and safety audits and performance measures being completed and reviewed.
- Senior management were not always visible. The trust scored below the national average for the proportion of staff who staff reporting good communication between senior management and staff in the NHS staff survey results, 2014.
- There was a theatre utilisation recovery programme being implemented and a programme to improve the inefficient use of the operating theatres. There was a range of clinical audits undertaken, but no reporting to the divisional board of audit results or action plans.
- The critical care unit had a local vision and strategy document, but this did not appear in the overarching five year strategy for the directorate. The draft strategy document had not been submitted to, or reviewed by, the directorate board and only had local oversight. None of the areas within the strategy had clear information and ideas about how these developments could, and/or would, be achieved.
- Financial constraints were limiting the ability to innovate and improve in some areas.
- Within maternity and gynaecology, there were effective, risk, quality and governance structures in place. However, current processes did not ensure the trust had a complete overview of all serious incidents.
- End of life care services were well led and had been seen as a priority with the development of a three year end of life strategy supported by a service review
- There was not a clear vision or strategy within outpatients. There were specialities working in silos with limited working on the outpatient processes.
- Diagnostic imaging had a clear governance process and staff were focused on providing a good service to their patients.

We saw several areas of outstanding practice including:

- The diagnostic imaging team had some areas of outstanding practice, one of which, the palliative ascites drainage, was highly commended by the British Medical Journal (BMJ) in 2015. Innovative practice was seen with the introduction of the intra operative breast radiotherapy project.

# Summary of findings

- In the critical care unit we were given examples of staff 'going the extra mile' for their patients, including a patient attending a family wedding in London, with transport being arranged by the unit and staff escorting the patient for the day.
- In maternity services consultants provided specialist pre and post pregnancy counselling and support service to women. This and other specialist clinics developed to manage high risk pregnancies had been recognised as best practice. The lead consultant had won an All-Party Parliamentary Group Maternity Services Award during 2011. This service style had since been adopted by other maternity services across the country and show-cased at Harvard, USA.
- Children were treated with respect and their ability to give consent for their own treatment was taken seriously.

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

Importantly, the trust must:

- Ensure staff receive up to date safeguarding, mandatory training appraisals and training on the Mental Capacity Act.
- Improve governance processes to demonstrate continuous learning, improvements and changes to practice as well as board oversight and assurance.
- Ensure there are sufficient numbers of midwifery staff to provide care and treatment to patients in line with national guidance.
- Ensure effective infection prevention and control measures are complied with by all staff.
- Ensure safe storage of medicines, including intravenous fluids.
- Improve the access and flow of patients in order to reduce delays from critical care for patients being admitted to wards and reduce occupancy to recommended levels.
- Review nurse staffing levels and skill mix in the emergency department (ED), including children's ED, the ED observation unit and minor injury units, using a recognised staff acuity tool.
- Take steps to ensure there are consistently sufficient numbers of suitably qualified skilled and experienced staff employed to deliver safe, effective and responsive care.
- Ensure all staff who provide care and treatment to children in the emergency department are competent and confident to do so.
- Make clear how patients' initial assessment should be carried out by whom and within what timescale within the ED.
- Monitor the time self-presenting patients wait to be assessed in the emergency department and take appropriate action to ensure their safety. This must include taking steps to improve the observation of patients waiting to be assessed so that seriously unwell, anxious or deteriorating patients are identified and seen promptly.
- Ensure that clinical observations of patients in the emergency department are undertaken at appropriate intervals so that any deterioration in a patient's condition is identified and acted upon.
- Risk assess and make appropriate improvements to the design and layout of the emergency department observation unit to reduce the risk of patients harming themselves or others.
- Clarify the use of the observation unit, setting out its purpose, admission criteria and exclusion criteria to ensure that patients admitted there are clinically appropriate and receive the right level of care.

# Summary of findings

- Ensure best (evidence-based) practice is consistently followed and actions are taken to continually improve patient outcomes.
- Ensure chemicals and substances that are hazardous to health (COSHH) are secured and not accessible to patients and visitors to the wards.
- Ensure sharps bins are used in accordance with manufacturer's guidance to prevent the risk of a needle stick injury.
- Ensure staff members are aware of the risk of cross infection when working with patients with isolated infectious illness.
- Ensure risk assessment tools in place to identify risks of thrombosis, pressure damage, moving and handling, nutritional and falls are consistently completed and appropriate action taken.
- Ensure National Early Warning Scores used to identify from a series of observations when a patient was deteriorating are appropriately actioned when high indicator scores were seen.
- Ensure that patients with mental health issues on medical wards are appropriately managed.
- Ensure appropriate review and action are undertaken when Deprivation of Liberty Safeguards have been put in place.
- Ensure consistent compliance with the Mental Capacity Act. Ensure all appropriate surgical patients have their mental capacity assessed and recorded to ensure consent is valid, and the hospital is acting within the law.
- Ensure patients' records are fully completed and provide detailed information for staff regarding the care and treatment needs of patients.
- Ensure the provision of single sex accommodation.
- Ensure all areas of the premises and equipment are safe and secure, and patient confidential information is held securely at all times.
- Ensure patients being admitted overnight to the day surgery unit have appropriate facilities which meet their needs, maintains their privacy and dignity, and reflects their preferences.
- Provide a responsive service to reduce waiting times and waiting lists for surgery procedures. Theatre efficiency, access and flow, delays, transfers of care, and bed occupancy must be improved to ensure patients are safely and effectively cared for.

In addition the trust should:

- Continue to take steps to improve patient flow, reduce overcrowding and reduce the time that patients wait in the emergency department.
- Take steps to ensure that patients attending the emergency department and minor injury units are greeted and receive care and treatment in areas which are conducive the exchange of private information.
- Clearly set out the objectives of initiatives designed to improve patient flow and the protocols which guide their use so that there is consistency of staff practice and engagement, and their effectiveness can be evaluated.
- Review shower and bathing facilities for inpatients to ensure safe access to appropriate shower facilities.
- Consider access to toilets in bays for patients who have visual or mobility issues to ensure a safe and clear route to the bathroom.
- Ensure topical medicines stored in sluices and used for multiple patients do not pose a risk of cross infection to patients.

# Summary of findings

- Have a consistent approach to recording patient allergies, including medicine allergies and intolerances.
- Undertake a review of discharge medicines practice to ensure patients do not experience unacceptable delays.
- Consider appropriate action to ensure future cover for the medical lead for the outlier team.
- Consider the implementation of a pain assessments tool for patients with limited communication.
- Review access to therapy services at the weekend to ensure patients receive the care they need.
- Review the systems in place for sending letters to GPs
- Review communication from ward to board to ensure staff are aware of the systems in place above divisional level.
- Ensure surgery staff report incidents in accordance with policy and are given time to do so.
- Ensure patient records in surgery services accurately report data. The use of question marks to replace knowledge of, for example, if a patient had eaten their meal, should not be permissible.
- Ensure the audit results of providing patients with an assessment for venous thromboembolism are accurate.
- Ensure arrangements in place to replace aging diagnostic imaging equipment identified as at risk of failure.
- Put systems and processes in place to ensure equipment is regularly checked.
- Accurately identify backlogs in patients requiring outpatient appointments.
- Undertake a staffing review of nursing and administration staff within the outpatients departments.
- Consider the development of patient forums for outpatients and diagnostic imaging.
- Ensure mortality and morbidity reviews are comprehensively recorded and lessons learned are shared locally and throughout the trust.
- Ensure medical equipment and devices are replaced when scheduled within critical care.
- Record non-compliance with the Core Standards for Intensive Care Units (2013) in critical care on the risk register to ensure continued focus on compliance.
- Review the security of confidential patient records in critical care to ensure they are safe from removal or the sight of unauthorised people.
- Develop an appropriate clinical audit programme in place so that patient care can be assessed, monitored and improved.
- Review the provision of the critical care outreach team service, to ensure patients can receive timely critical care input in the wider hospital environment.
- Review the role of the clinical nurse educator within critical care to ensure adequate time and resources are given to this essential post in line with best practice and the Core Standards for Intensive Care Units (2013).
- Ensure critical care is included in major incident exercises.
- Review the provision of dietitians and speech and language therapists to ensure critical care patients are adequately supported.
- Review policies and procedures for critical care step down, handover and discharge to ensure patients are adequately supported at all stages of their care.

# Summary of findings

- Review the provision of care to patients in critical care to ensure compliance with National Institute for Health and Care Excellence (NICE) guidance 83 in relation to some parts of patient rehabilitation, including discharge advice and guidance and follow-up clinics.
- Review the process for HIV screening and results feedback in the critical care unit to ensure patients are kept informed.
- Ensure critical care strategies and future plans are approved and incorporated into the overarching strategy of the division.
- Ensure all equipment has up-to-date maintenance checks.
- Improve the maternity and trust IT systems to remove duplication and increase accessibility.
- Ensure gynaecology inpatients do not have their elective inpatient treatments cancelled as a result of other medical and surgical patients admitted to Beech ward.
- Review actions to recruit and retain specialist gynaecology nurses.
- Ensure processes are in place to reduce the risk of mothers taking an incorrect feed by mistake.
- Ensure protocols are in place and followed to maintain confidentiality of patient information.
- Ensure assessment charts can be used as designed to highlight patients at risk.
- Ensure levels of safeguarding training and knowledge for medical staff is in line with national guidance.
- Review the environment in which children are cared for and the exposure risk to adult behaviours.

**Professor Sir Mike Richards**

Chief Inspector of Hospitals

# Summary of findings

## Our judgements about each of the main services

### Service

#### Urgent and emergency services

Requires improvement

### Rating



### Why have we given this rating?

We rated safety in urgent and emergency services as Inadequate. There was limited evidence that learning from incidents was acted upon quickly to ensure that similar events did not reoccur. Staff expressed concerns about nurse staffing levels, with shifts in the emergency department (ED) regularly under-staffed, resulting in patients waiting too long for their initial assessments, observations not being undertaken with the required frequency, and records not being completed accurately. Staffing levels did not take into account the requirement to care for patients who queued in the corridor or the sub-waiting room. There were concerns about the level of staffing, the lack of appropriate skills and the experience of staff working in the children's ED and the ED observation unit. The design and layout of the emergency department meant waiting patients, including children, were not observed. The physical isolation of the observation unit and the design and layout of the ward were unsuitable for patients who had been assessed as being at high risk of harming themselves or others, presenting unacceptable risks to the safety of other patients and staff. There were inadequate safeguards in place on the observation unit to protect older people from the risk of falls.

Effectiveness was rated as requiring improvement. There were recognised national clinical guidelines in place but very little evidence was available to show that these were complied with or that people received good outcomes because practice was not regularly audited. Junior medical staff were well supervised, felt well supported by their seniors and received regular teaching. However, nurse education did not take place in a structured or consistent way and we could not be assured that all nurses were able to regularly update their skills. Caring was rated as good. Patients and their relatives told us they were treated with kindness, compassion, dignity and respect. Patients and their relatives were kept informed and involved in decisions about care and treatment.

## Summary of findings

Responsiveness was rated as requiring improvement. Services were not always organised and delivered so that patients received the right treatments at the right times. The service did not consistently meet waiting time targets. At busy times departments were overcrowded and patients queued in the corridor. Some patients experienced long waits and there were frequent delays for patients who required admission because there were insufficient beds available in the hospital. These waits and delays impacted on patients' comfort, privacy and dignity. There was inappropriate use of the observation unit. Patients with mental health needs were not always assessed promptly by a mental health practitioner. These patients also sometimes spent too long on the ED observation unit, which was not a suitable therapeutic environment for their potentially distraught, agitated or suicidal states.

Premises and facilities were not always fit for purpose. Some accommodation was cramped and this was not conducive to the exchange of confidential information.

Improvement plans had been developed, although staff had not been engaged with changes in service provision. A number of initiatives had been introduced to address responsiveness and improve performance against national standards. These initiatives were in their infancy and their success had yet to be evaluated. The objectives of these initiatives still needed clarification and their protocols and processes needed to be fully developed so that they were understood by staff and staff were fully engaged in making them a success.

Leadership was rated as requiring improvement. The service had engaged with external bodies to assess and evaluate its performance. Improvement plans had been developed, although staff had not been engaged with this process or changes in service provision and the plans did not form part of well-developed strategy or vision for the future. A number of initiatives had been introduced to address responsiveness and improve performance against national standards. Although commendable, these initiatives were in their infancy and their success had yet to be evaluated.

# Summary of findings

The risks to patient safety and quality were well understood but they were not fully captured in the service risk register. Risks identified as a result of serious incidents were not always dealt with in a timely way. Audits were not consistently used to drive service improvement. Staff were committed and highly motivated. They worked well as a team and were well supported by their immediate managers, although they did not always feel engaged or empowered.

## Medical care (including older people's care)

### Requires improvement



We rated safety in the medical services, including older people's care, as requiring improvement. There were periods of understaffing or inappropriate skill mix which were not fully addressed. We saw infection control procedures and the storage of equipment and chemicals were not always safe. Staff did not always respond promptly to the care and treatment needs of a deteriorating patient, or fully consider the needs of patients with mental health issues. The completion of records did not consistently reflect the care needs of patients.

Effectiveness of medical services was rated as requiring improvement. The tools used to measure and monitor pain relief and nutritional risks were not consistently completed and used to develop patient care plans. Consent to care and treatment was not consistently obtained in line with legislation and guidance, including the Mental Capacity Act 2005. We found that patients' mental capacity had not been consistently assessed and recorded when necessary. It was not always clear how best interest decisions had been made. Staff did not monitor Deprivation of Liberty Safeguards some of which had expired without staff being aware.

We found the service provided was caring and that the staff involved and treated people with compassion, kindness, dignity and respect. However, many patients told us they did not know what the ongoing plan was for their care and treatment, and felt communication of this information was poor.

Responsiveness of medical services was good. Services were planned and delivered to be flexible and meet the needs of the local population.

# Summary of findings

Facilities and premises were appropriate for the services delivered to patients. The management of access and flow through the hospital and the management of outlying patients on other wards was good. Some difficulties were encountered on discharge.

The leadership of medical services required improvement. Staff were confident at ward level about the leadership of matrons and managers. Few had understanding or awareness of the hospital management above that level. There was some misunderstanding outside of ward areas of the level of care provided on the Coronary Care Unit and Mercury ward. This did not ensure clear leadership of the medical service.

## Surgery

### Requires improvement



Nursing staffing levels were leading to patients not being provided with quality and safe care at all times. There had been a significant breach of patient record confidentiality with confidential medical records left in the unoccupied and unlocked day surgery on a weekend. The hospital trust took urgent action and rectified this situation. We received a full and satisfactory report of the remedial action taken.

Not all incidents were being reported to enable them to be investigated and responded to and mortality and morbidity reviews did not demonstrate how the service was focused upon improvement to quality and safe care. Staff updating their mandatory training was not meeting trust targets.

Safety was good within operating theatres. Most areas of the hospital were clean and infection prevention and control protocols followed, although audit results were contradictory. Medicines were mostly safely managed, as were equipment and the environment. There was a safe level of cover from the medical staff.

Length of stay in the hospital was better than the England average. Patients' pain, nutrition and hydration were mostly well managed with specialist input when needed. Staff were skilled and experienced, although not all had received an

# Summary of findings

annual performance review. There was strong multidisciplinary input to patient care. Important services were provided seven days a week and there was good access to information.

Feedback from patients and their families had been positive overall. The Friends and Family Test produced excellent results. Patients we met in the wards and other units spoke highly of the kindness and caring of all staff. Staff ensured patients experienced compassionate care, and worked hard to promote their dignity and human rights, even though this may have failed at times. The main criticism was staff not having the time to provide more than basic care at times, although wanting to provide a higher standard.

The use of the day surgery to admit patients meant not all their needs were being met. The hospital was in a period of failing to meet the referral to treatment times for almost all surgery specialties and waiting times were worse than average. Bed occupancy was high and patient access and flow was poor at times. The hospital was regularly faced with a high number of patients who were fit for discharge, but without transfer of care packages. Cancelled operations were low, and the pre-admission, admission and discharge services provided good support.

The more complex needs of patients were met, but there was little innovative support for patients living with dementia within the surgery wards. Complaints were addressed, but the evidence of how they improved the quality and safety of care was limited.

The service lacked a cohesive clinical governance structure demonstrating learning, change and improvement. There was good leadership and local-level support for staff. All the staff we met showed commitment to their patients, their responsibilities and one another. There was a strong camaraderie within teams. We were impressed with the loyalty and attitude of the staff we met.

## Critical care

Requires improvement



We have judged the critical care services overall as requiring improvement, although with some areas

## Summary of findings

of good practice. The safety and governance arrangements required improvement. However, the service was providing effective, caring and responsive treatment and care to patients. Incident reporting was inconsistent and opportunities for learning were not always being identified. Reviews of patient mortality and morbidity were not leading to learning in the unit, or shared across the wider trust. Mandatory training compliance was below target and there were areas of concern with infection prevention and control. Intravenous fluids were not being kept in locked storage, which left them at risk of tampering. The unit had strong leaders but the governance arrangements were not robust or effective. There was no demonstration that lessons were being learned or of changes being made to improve the service. There was a five year strategy but it was not cited or approved by the directorate, or aligned with the trust's five year strategy. It contained areas for development and strengthening in the unit, but did not show how this could be achieved. Staff satisfaction was high and they told us managers were open, honest, fair and visible. Care and treatment was generally planned and delivered in accordance with current evidence-based guidance, standards, best practice and legislation. Patients' needs were assessed and multidisciplinary teams worked to support treatment plans. A shortage of speech and language therapists, however, meant some patients' swallowing and communication needs were not always responded to promptly. Staff had a good knowledge of the Mental Capacity Act, Deprivation of Liberty Safeguards and restraint. Patient outcomes were monitored and reported nationally, with the unit showing it was performing well against other units. Training and development opportunities were not prioritised in the unit, and the lack of a full time clinical nurse educator risked learning needs not being identified or managed. Patients were supported, treated with dignity and respect, and were involved as partners in their care. Patients and their family or friends were involved with decision making. They were able to ask questions and raise anxieties and concerns and receive answers and information they could

# Summary of findings

understand. Staff treated patients with kindness and warmth. The unit was busy, but staff always had time to provide individualised care. Staff talked about patients compassionately, with knowledge of their circumstances and those of their families. Services were planned and delivered to meet the needs of the local population, with comfortable facilities available for patients and visitors. Services were equally accessible for all, and no discrimination (unintended or otherwise) was being demonstrated in how services were delivered. Facilities were, on the whole, appropriate for the services being delivered; however, overnight visitors and patients had to share a single shower room. Delays and cancellations as a result of bed unavailability in the unit were minimal; however, there were some discharge delays due to pressures with beds elsewhere in the hospital. The unit had a clear system for the investigation of complaints, including involvement of, and feedback to, patients, relatives and staff.

## Maternity and gynaecology

Good



Overall, we have judged the maternity and gynaecology services to be good for responsive, effective, caring and well-led services. Overall, we have judged safety in the maternity service requires improvement.

Care in both the gynaecology and maternity wards and central delivery suite was consultant led. Patients had risk assessments completed and reviewed regularly. There were established and thorough safeguarding procedures in place. Systems were in place which ensured women who required emergency obstetrics and gynaecology treatment and care were seen promptly by specialist nurses and consultants at all times. Clinical procedures were provided in line with national guidance and policy.

Safety improvements were required to the maternity services. The midwifery staffing levels did not comply with the Health and Social Care Act (2008) Code of Practice on staffing. The midwife to patient ratio exceeded (was worse than) recommended levels and one to one care for women in established labour was not achieved 100% of the time.

# Summary of findings

The maternity services were responsive to the needs of local women and those living outside of the locality of the hospital. The majority of patients were satisfied with the care and treatment they received and would recommend services. We saw records documenting patient's choices and preferences. Additional specialist counselling was available to patients as required. Access and flow through the gynaecology inpatient service had been affected by intense trust wide service pressures. At departmental levels there were effective, risk, quality and governance structures in place. Incidents, audits and other risk and quality measures were reviewed for service improvements and actions taken. Improvements were required to risk management processes at a senior level to ensure a complete overview of all serious issues and actions was maintained, and escalated to the board.

At departmental levels, systems were in place to effectively share information and learning. There was a positive culture and staff were proud of the patient care they provided and spoke of good and productive team working practices. Consultant, nursing and midwifery leadership was described as good, junior staff were well supported and departmental senior managers were visible and approachable. There was strong evidence from the midwives and consultant obstetricians of innovations completed to improve treatment, care and outcomes for patients.

## Services for children and young people

### Requires improvement



We have judged the services for children and young people overall as requiring improvement. We found the safe and well led domains required improvement. However, the service was providing effective, caring and responsive treatment and care to children and young people and their families. People who used the services told us that they felt safe, although we found evidence that there was some risk in staffing levels on the ward and in SCBU. Staffing levels were often below recommended levels on the children's ward and SCBU. Children were cared for alongside adults and were able to witness adult behaviour that could be distressing to a child or young person.

# Summary of findings

Staff at all levels were caring, supportive and keen to do the best job they could.  
We found the services to be well led at a local level. Staff felt able to raise issues with local management and felt they were listened to and understood, but not all staff felt engaged with or knew the identities of senior trust executives.

## End of life care

Good



We judged the overall service provision of end of life care as good. We found the service to be safe, effective, caring, responsive and well-led. End of life care was seen as a priority for the trust. There was a clear overarching strategy for the service and plans to improve the delivery of care had already begun to take place with good results. Education programmes had been developed and delivered, new documentation had been successfully introduced to the trust improving the pathway for patients although there was also some, yet to be fully embedded. Staff, patients and relatives spoke in high regard for the specialist palliative care team; they were seen as responsive to the needs of both patients and staff. Out of hours there were good resources for staff to access including a 24 hour advice line managed by specialist palliative care nurses at a local hospice. End of life care was responsive to the needs of patients and relatives. The end of life service was flexible and provided choice and accommodated individual needs for the patient and carers. The specialist palliative care team had been involved in looking at complaints and incidents, as part of a wider team, and were keen to ensure training and teaching sessions were tailored and disseminated to ensure future complaints were minimised and care of patients was enhanced. The specialist palliative care team were dedicated members of a cohesive team working to deliver effective care and treatment plans for patients, offering advice and acting as a resource for clinical teams.

## Outpatients and diagnostic imaging

Requires improvement



We judged outpatients and diagnostic imaging services as requiring improvement within the safe, responsive and well led domains.

# Summary of findings

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The service was caring. Patients were positive about the way staff treated them and we saw staff working hard to meet the needs of patients. There was inconsistency of approach and processes across outpatients in regards to infection control and safety checks with a variance in safeguarding and mandatory training compliance. There was inconsistent clinical governance. This meant the trust could not be assured that safe, effective care was being provided in this service.

Within diagnostic imaging there was innovative work and excellent multidisciplinary work both within and outside the hospital.

Many staff in outpatients told us the trust was reactive rather than proactive. There was a risk that equipment failure in diagnostic imaging and ophthalmology could result in delays in patients receiving treatment. There were backlogs in some specialities that meant delays in some patients getting timely treatment.

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# Great Western Hospital

## Detailed findings

### Services we looked at

Urgent & emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and Gynaecology; Services for children and young people; End of life care; Outpatients & Diagnostic Imaging

# Detailed findings

## Contents

Detailed findings from this inspection	Page
Background to Great Western Hospital	22
Our inspection team	22
How we carried out this inspection	23
Facts and data about Great Western Hospital	23
Our ratings for this hospital	24
Findings by main service	25
Action we have told the provider to take	209

## Background to Great Western Hospital

Great Western Hospitals NHS Foundation Trust provides a number of services across Wiltshire, to a population of around 480,000 people in Wiltshire and the surrounding areas, with acute services provided at the Great Western hospital, Swindon. The hospital was built under the Private Finance Initiative at a cost of £148million and opened in 2002. The trust became a foundation trust in 2008.

Wiltshire Local Authority is in the 40% least deprived areas in the country. 19.0% of the population are under 16 (equal to the percentage in England). The percentage of people aged 65 and over is 19.5% (higher than the England figure of 17.3%). There is a lower percentage of Black, Asian and Minority Ethnic (BAME) residents (3.6%) when compared to the England figure (14.6%).

We conducted this inspection as part of our in-depth hospital inspection programme. The trust was identified

as a low risk trust according to our Intelligent Monitoring model. This model looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations.

The inspection team inspected the following eight core services:

- Urgent and emergency services
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology
- Services for children's and young people
- End of life care
- Outpatients and diagnostic imaging

## Our inspection team

Our inspection team was led by:

Chair: Dr Nick Bishop, Senior Medical Advisor, Care Quality Commission

Head of Hospital Inspections: Mary Cridge, Care Quality Commission

The team included of 58 people included 17 CQC inspectors and a variety of specialists: A retired chief

executive, a director of nursing, a safeguarding specialist, a paramedic, a senior sister in emergency medicine, a consultant surgeon, a consultant in anaesthesia, a consultant neonatologist, a consultant in paediatric palliative care, a consultant haematologist, four community matrons, a health visitor, a speech and

# Detailed findings

language therapist, two physiotherapists, an occupational therapist, specialist nurses in end of life care, medicine and maternity, a junior doctor, a student nurse and an expert by experience.

## How we carried out this inspection

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about Great Western Hospital NHS Foundation trust and the Great Western Hospital. These included the local commissioning groups, Monitor, the local council, Healthwatch Swindon and Healthwatch Wiltshire, the General Medical Council, the Nursing and Midwifery Council and the royal colleges. We also talked to the provider of community services in Swindon, and the company who own, run and manage the hospital building, providing domestic and portering staff, meals and facilities management.

We held one listening event in Marlborough on 24 September 2015, at which people shared their views and experiences. In addition we ran a 'share your experience' stall in a shopping centre in Swindon on 22 August 2015.

In total more than 50 people attended the events. People who were unable to attend either shared their experiences by email and telephone as well as on our website.

We carried out an announced inspection on 29 and 30 September and 1 and 2 October 2015. In addition we undertook unannounced inspections on Sunday 11 and Thursday 15 October 2015. We held focus groups and drop-in sessions with a range of staff, including nurses, junior doctors, consultants, student nurses, administrative and clerical staff, physiotherapists, occupational therapists and pharmacists. We also spoke with staff individually as requested.

We talked with patients and staff from across most of the trust. We observed how people were being cared for, talked with carers and family members, and reviewed patients' records of their care and treatment.

## Facts and data about Great Western Hospital

The hospital has a total of 450 beds (including 12 critical care beds and 38 maternity beds). 721.8 whole time equivalent (WTE) staff are employed to provide acute healthcare services to a population of around 480,000 people from Wiltshire and the surrounding areas.

Between July 2014 and June 2015 there were a total of 84,762 inpatient admissions including day cases, 490,740 outpatients' attendances (both new and follow-up) and 78,519 attendances at the emergency department.

At the end of 2014/15, the trust had a financial deficit of £6.2 million.

Bed occupancy was consistently above 92%, with occupancy 95% during quarter 4 2014/15. This was above the England average (85.9%) and above the level, 85%, at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients and the orderly running of the hospital.

The Finance Director and the Deputy Chief Operating Officer were new into post at the time of the inspection. The rest of the executive team and non-executive team were stable.

### CQC inspection history

Since registering with CQC, there had been a total of Eight inspections covering a total of 16 outcomes. The most recent inspection occurred in December 2013 where six outcomes were inspected. The trust was found to be non-compliant in outcomes 1, 4, 8, 13 and 16 (Respecting and involving people who use services; Care and welfare of people who use services; cleanliness and infection control; staffing; assessing and monitoring the quality of service provision.) The trust was found to be compliant with outcome 21 (records).

# Detailed findings







## Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Maternity and gynaecology	Requires improvement	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

## Notes

# Urgent and emergency services

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

## Information about the service

Urgent and emergency services at Great Western Hospital (GWH) are provided by an unscheduled care division. The emergency department (ED), otherwise known as the accident and emergency department, operates 24 hours a day, seven days a week. The ED saw approximately 78,553 patients in 2014/15, of whom 17,645 (22.5%) were children. Patients who present with minor illnesses may be redirected to the nurse-led urgent care centre located on the GWH site or to the co-located GP out-of-hours service. This unit was run by a community health services provider and did not form part of this inspection.

Adult ED patients receive care and treatment in two main areas: minors and majors. Self-presenting patients with minor injuries are assessed and treated in the minors' area. Patients with serious injuries or illnesses who arrive by ambulance are seen and treated in the majors' area, which includes a resuscitation room. The majors' area is accessed by a dedicated ambulance entrance.

There is a dedicated children's unit with a separate waiting area and a treatment area with five private cubicles. At the time of our visit this unit was not consistently open 24 hours a day due to staffing difficulties.

The ED is a designated trauma unit and provides care for all but the most severely injured trauma patients. Severely injured trauma patients are usually taken by ambulance to the major trauma centres in Bristol or Oxford if their

conditions allow them to travel directly. Such patients are otherwise stabilised at GWH before being treated or transferred as their conditions dictate. The ED at GWH is served by a helipad.

There is an eight-bed observation unit that allows for further assessment of patients who are likely to require treatment for between four and 24 hours but are unlikely to require admission.

There are minor injury units (MIUs) based at Chippenham Community Hospital and Trowbridge Community Hospital. These units are nurse-led by emergency nurse practitioners (ENPs). ENPs are specially trained nurses who are able to see, treat and discharge patients. The MIUs combined saw 28,650 patients in 2014/15 of whom 8,412 (29%) were children. The MIU at Chippenham Community Hospital is open from 7am to 1am, seven days a week while the unit at Trowbridge Community Hospital is open 24 hours a day, seven days a week. X-ray facilities are available from Monday to Friday. The MIUs provide a walk-in service for patients with minor injuries such as minor cuts and wounds, minor burns and scalds, simple fractures, strains and sprains. The service is not set up to provide treatment for minor illnesses, although it was estimated that approximately 20% of attendances are patients with minor illnesses. Most patients with minor illnesses are referred to their GP or to the out-of-hours GP services that are co-located with the MIUs. Patients who present with serious injuries or illnesses are stabilised as appropriate and arrangements are made to transfer them to the nearest acute hospital.

We visited the ED over two and a half weekdays and conducted a further unannounced visit during a weekday

# Urgent and emergency services

evening. We spent half a day in each of the MIUs, with one visit taking place at the weekend. We spoke with approximately 30 patients/relatives as well as staff including nurses, doctors, managers, therapists, support staff and ambulance staff. We observed care and treatment and looked at care records. We received information from our listening events and from people who contacted us to tell us about their experiences. We reviewed performance information about the trust and other information from the trust both prior to and following our inspection.

## Summary of findings

Capacity and overcrowding presented significant challenges in urgent and emergency care. Lack of patient flow in the hospital meant that patients who had been seen in the emergency department (ED) and required admission were delayed because there were no available beds. Patients frequently queued in the corridor in the ED because there were no available cubicles in the department. This situation impacted patient comfort, privacy and dignity. Patients awaiting a medical or surgical speciality bed were frequently admitted inappropriately to the ED observation unit. This further impacted the effectiveness of the unit and reduced ED capacity. These patients were not always reviewed promptly by the appropriate specialty.

The service was not consistently staffed by sufficient numbers of appropriately qualified, experienced and skilled nursing staff. This sometimes put patients at risk. Particular causes for concern were staffing levels and skill mixes in the observation unit and the children's ED. Many staff expressed frustration, disappointment or inadequacy because they felt unable to provide their desired level of care to patients during busy times.

Premises were not always fit for purpose. Although departments were clean, well maintained and mostly appropriately equipped, their design and layout meant that waiting patients, including children, were not adequately observed. The physical isolation of the observation unit and lack of environmental safeguards, combined with inadequate staffing levels and skills, posed unacceptable risks to patient and staff safety. Some accommodation in the ED and minor injury units (MIUs) was cramped and not conducive to the exchange of private conversations or the protection of patients' privacy and dignity.

Risks were understood but not always well managed. There were few serious incidents in urgent and emergency care but also only limited evidence that learning arising from incidents was put into practice. The risk register did not reflect multifactorial risks to patient safety and care quality and therefore was not an effective tool.

# Urgent and emergency services

The service had engaged with external bodies to assess and evaluate its performance. Improvement plans had been developed, although staff had not been engaged with this process or changes in service provision and the plans did not form part of well-developed strategy or vision for the future. A number of initiatives had been introduced to address responsiveness and improve performance against national standards. Although commendable, these initiatives were in their infancy and their success had yet to be evaluated.

Patients were mostly satisfied with the care and treatment they received. Friends and family test results were mainly positive, mirroring the feedback we received during our visits. Staff were described as caring, respectful and supportive. Patient outcomes were felt by the management team to be generally good, although there was limited evidence to support this judgment. The service participated in national audits to benchmark their practice. Performance in these audits was variable and showed room for improvement. Improvement plans were not always progressed quickly.

Staff enjoyed working in the service. Morale was remarkably good despite daily staffing challenges. This morale level was testament to the management team who were highly regarded, visible and supportive. There was good senior medical staff presence in the ED and junior medical staff felt well supported. Junior medical staff received regular teaching, supervision and mentorship. Nurse education was conducted on a more ad hoc basis, with no structured approach to teaching and clinical supervision. There was a paucity of information with regard to the skillset of nurses working in the ED and MIUs, and so we could not be assured of their competence.

## Are urgent and emergency services safe?

Inadequate



Patients were not adequately protected from the risk of avoidable harm. Although there were few serious incidents reported and all reported incidents were fully investigated, there was limited evidence to show that learning was acted upon quickly to ensure that similar events did not reoccur.

Most staff expressed concerns about nurse staffing levels and how these levels impacted the service during surges in demand. Shifts in the emergency department (ED) were regularly under-staffed. We saw that patient care suffered during one busy shift, with patients waiting too long for their initial assessments, observations not being undertaken with the required frequency, and records not being completed accurately.

Staffing levels in the ED did not take into account the requirement to care for patients who queued in the corridor or the sub-waiting room. We had particular concerns about the level of staffing, the lack of appropriate skills and the experience of staff working in the children's ED and the ED observation unit.

Premises were clean and mostly appropriately equipped. However, the design and layout of departments we inspected meant that waiting patients, including children, were not observed. The physical isolation of the observation unit and the design and layout of the ward were unsuitable for patients who had been assessed as being at high risk of harming themselves or others. This unsuitability presented unacceptable risks to the safety of other patients and staff. There were inadequate safeguards in place on the observation unit to protect older people from the risk of falls.

Following our inspection we raised some serious concerns with the trust and required that they provide us with assurance that there were robust plans in place to promptly address these concerns. Their response did not provide enough assurance that had developed plans to address these. We will require further assurance that improvement plans are progressed in a timely manner.

## Incidents

# Urgent and emergency services

- There were four serious incidents reported in ED between May 2014 and April 2015. These were all subject to a root cause analysis. Incidents were categorised as follows:
  - Failure to act upon test results (delayed CT scan for a patient with a head injury)
  - Sub-optimal care of the deteriorating patient (delayed treatment of severe sepsis)
  - Other (multiple delayed admissions [more than 12 hours]) from ED
  - Slips trips and falls (fall on observation unit resulting in a fracture)
- Safety thermometer data (data collected on a single day in each month and used to record patient harms) for the period June 2014 to June 2015 showed:
  - There were no pressure ulcers reported
  - There were five falls reported (none reported since November 2014)
  - There were two catheter acquired urinary tract infections reported
- Incidents and lessons learned from them were discussed at monthly clinical governance meetings. However, there was limited evidence of learning from serious incidents.
  - The action plan following investigation of a patient fall in the ED observation unit in December 2014, stated that a falls risk assessment and care planning document (known as SAFE) would be introduced for all patients over 65 in this department. Completion of this documentation was to be audited monthly.
  - We were provided with the results of a patient documentation audit undertaken in June/July 2015. This showed that 80% of the records audited had a falls risk assessment completed. The audit did not specifically look at completion of SAFE but a very basic risk assessment completed for all patients on admission. The National Institute for Health and Care Excellence (NICE) recommends that older people should have falls risk assessment undertaken when they are admitted to hospital. Patients who have presented due to a fall should have a multifactorial risk assessment undertaken.
  - We asked a staff member in the observation unit to show us the SAFE documentation. They could not locate it in the department. They sought advice from a colleague in ED and were informed that the paperwork they used previously had been withdrawn approximately a month ago and they were now required to use the falls risk assessment pro forma which formed part of the inpatient personalised care plan. We looked at the records for a patient on the unit who was 90 years old and who had been identified by their carer on admission as being at risk of falls. Neither the simple nor the more detailed falls risk assessment had been completed for this patient and we judged that inadequate steps had been taken to prevent this person falling when they tried to climb out of bed.
- Following our inspection we shared our concerns with the trust with regard the inadequate arrangements to safeguard older people admitted to the observation unit from the risk of falls. They acknowledged that the SAFE falls risk assessment and care planning documentation had not been introduced on the observation unit and that the trust-wide standard care planning documentation was not fully embedded on this unit. They advised us that older people would no longer be admitted to the observation unit and would in future be admitted to the acute medical unit and assessed by the elderly care team
- Following a patient death (delayed treatment of severe sepsis) in March 2015 clinical pathways were reviewed and teaching sessions in sepsis management were arranged for ED staff. Support with the pathway was being provided by a specialist nurse
- Following a serious incident in June 2014 where a patient's head injury was not treated in accordance with NICE guidelines, refresher training in the management of head injuries was delivered. The action plan developed following a root cause analysis of this incident stated that an audit of the management of head injuries in intoxicated patients was to be undertaken by October 2014. The trust told us that this audit had not yet taken place but would take place in the next six months
- It was recorded in the minutes of a clinical governance meeting in May 2015 that, following an incident where a patient was violent and aggressive towards staff, further conflict resolution training had been arranged. Some staff confirmed they had attended further training, although the roll out of this

# Urgent and emergency services

was still ongoing. Following our inspection the trust confirmed that 87% of staff had received advanced conflict resolution training, although supporting data provided showed that only 71.2% had received this. Further training dates were scheduled in December 2015. It was also recorded that, following an incident of inappropriate disposal of instruments and sharps, posters were displayed in ED reminding staff of appropriate disposal processes. We saw no such posters during our visit.

- Staff reported that they were neither encouraged, nor discouraged from reporting incidents. Similarly, findings varied as to whether they received adequate feedback when they reported incidents. We saw however that incidents were discussed at team meetings so that learning could be shared
- There were monthly mortality and morbidity meetings where the care of patients who had complications or unexpected outcomes could be reviewed. Although these meetings were not always well attended, we were told that lessons learned were disseminated via the intranet.
- There was a Duty of Candour (being open) Policy (July 2015) and senior staff were familiar with this policy and their responsibilities. Although not all of the staff we spoke with understood the term, they all understood the importance of being open when mistakes were made and believed that the service acted within the spirit of the regulation. The division maintained a duty of candour register and we saw evidence that the regulation was being complied with

## Cleanliness, infection control and hygiene

- In CQC's 2014 A&E survey the trust scored 8.6 out of 10 for the question which asked whether the ED was clean.
- Departments were tidy and visibly clean. Cleaning was carried out throughout the day until 7pm. There were no dedicated cleaning staff at night but staff could be called for urgent cleaning tasks.
- There were appropriately sited hand wash basins and hand gel dispensers. We saw staff washing their hands and observing standard infection control precautions; they wore appropriate protective clothing, which was in plentiful supply, and observed the 'bare below the elbow' policy. We saw numerous staff however, walking

around the department wearing gloves and aprons; they did not remove this protective clothing between patients and tasks, thereby increasing the risk of cross infection. Waste was appropriately segregated, labelled and disposed of.

- Monthly infection control audits were carried out in the ED and MIUs. The ED scored 100% in all elements, with exception of patient equipment which scored an average of 94.6% in the year to date (April to August 2015). The observation unit scored 100% in all elements, as did the MIU at Trowbridge. Audit results for Chippenham MIU showed room for improvement with scores of 97.5% in hand hygiene and 94.1% for compliance with dress code.
- In the ED and in the MIU at Chippenham Hospital there were assessment/treatment rooms where infectious patients could be isolated.

## Environment and equipment

- The ED underwent refurbishment in 2013. Changes were made to the layout of the department, resulting in the creation of a central area where all clinical staff operated from. This was designed to speed up decision making and to allow medical staff to monitor an increased number of critically ill patients at the same time. There was a glass fronted office, known as the 'fish bowl', in this central area where staff could make private telephone calls but still be visible and still maintain a view of what was going on in the department. The medical staff handover also took place here, allowing medical staff a confidential space to discuss patients, whilst maintaining observation of the department.
- However the design and layout of departments presented challenges in respect of observing patients and keeping people safe.
- The division's risk register recorded a risk of "potential harm to staff and other patients as a result of an inappropriate environment for mental health patients in the Emergency Department observation bay." The department was physically separate from the ED and this led to a feeling of isolation and vulnerability for staff working there. A business case was being prepared to support a re-design of the observation unit, although it was not clear, in the context of the trust's financial difficulties, if or when improvements to the environment would be made. The Emergency Care Intensive Support

# Urgent and emergency services

Team (ECIST) commented on the location of the observation unit following their visit in May 2015. They recommended that the trust give early attention to the plans to move the department closer to the ED so that this could be achieved before winter. Following our inspection the trust advised that after the ECIST visit in May 2015 a project had been established to review the short and long term direction of the observation unit, including criteria, location and facilities. They assured us this was actively progressing as a project but there was no timescale agreed in which the relocation would be delivered.

- There were similar concerns expressed by staff about the safety of the children's ED. This was a dedicated children's facility located adjacent to the main ED. The department consisted of a waiting room at the end of a corridor, on which four cubicles and a nurses' station were situated. There was no line of sight from the nurses' station to patients in the waiting room or in cubicles (except the cubicle nearest the station which had a window). Design guidance set out in Health Building Note 15-01: Accident and emergency departments (April 2013) recommends that the children's waiting area "should be provided to maintain observation by staff but not allow patients or visitors within the adult area to view the children waiting." The layout of the department, combined with the level of staff in the area, meant that children, particularly those in the waiting room, could not be easily observed. Two staff told us they had raised concerns about this but there had been no change. They expressed disappointment that they had not been involved in the design of the department which was reconfigured recently. Staff told us they had requested a CCTV monitor to help with this but they were unsure as to when this would be provided.
- Following our inspection we raised our concerns with the trust with regard to the lines of sight within the children's ED. They told us that no incidents had been formally raised regarding the observation of children in this department. They agreed to review the area to see how it could be better managed and to give consideration to introducing signage and alarms.
- There was a separate waiting room for children in the children's ED. This had restricted access and was not

overlooked by the adults' waiting area. However, due to staffing constraints the children's unit was not open at night which meant children waited in the main department alongside adult patients.

- Lines of sight to the waiting room were restricted in both the ED and the MIU at Chippenham Hospital. This meant reception and clinical staff may not be aware if a patient's condition deteriorated or if patients' or visitors' behaviour put other people at risk. The Royal College of Emergency Medicine (RCEM) recommends in its Triage Position Statement 2011 that in the triage environment, consideration should be given to visualisation of the waiting environment. In the ED, waiting patients could not be easily observed by reception or nursing staff because of the layout of the area. The way in which seating had been configured also meant that patients were seated with their backs to the reception desk.
- In the MIU at Chippenham Hospital, the main waiting room could be partially observed by reception staff, aided by a CCTV monitor. However the children's waiting room could not be observed. The nurse's station and treatment areas were along the corridor and nurses did not often enter the waiting area but used an intercom to summon patients. This meant that patients' conditions went unobserved for sometimes long periods of time while they waited to be seen.
- In the MIU at Trowbridge Hospital there were separate waiting rooms for adults and children, with the children's waiting room located physically separate from the department. Neither of the waiting rooms were directly observed; although both could be viewed via CCTV at the nurses' station. However, at busy times they were unlikely to be observed and staff entered the areas infrequently, using an intercom loudspeaker to summon patients.
- Overcrowding in the ED was an issue at busy times. Staff told us that patients regularly queued in the corridor. Although we did not see this very often during our day time visits we saw a number of patients queuing in the corridor, both on arrival in the department and whilst waiting for transfer to a bed. In majors some patients waited in the sub waiting room in order to free up cubicles. They could not be easily observed in this area.

# Urgent and emergency services

In the evening this area was overflowing on to the corridor. The number of people in the department sometimes obstructed the movement of patients and equipment around the department.

- Overcrowding was also sometimes a challenge in the MIU. The waiting room was shared by the outpatients department and the out of hours GP service. Staff told us that the waiting room sometimes overflowed and patients had to be seated in the x-ray waiting room further up the corridor, where they could not be observed.
- There was a private room in ED which had been designated a mental health assessment room. There was a similar room attached to the observation unit. These rooms had been furnished to ensure there were no ligature points and nothing that could be used as a missile. There was an alarm system so that staff could summon help but the rooms were not fitted with two doors (that open both ways) as recommended by the RCEM and the Psychiatric Liaison Accreditation Scheme (PLAN). The trust and the staff were aware of this shortfall and told us they risk assessed each situation each time these rooms were used and took appropriate steps to ensure staff and patient safety.
- Departments were mostly well equipped; however consumable equipment and materials were not always appropriately and safely stored. In the corridor in ED, which could be accessed by patients, we found three storage units were left open. They contained items including needles, venflons and dressings. A staff member locked these units when it was drawn to their attention. The sluice in the ED was unlocked and within we found an unlocked cupboard containing hazardous substances (chlorine granules and hydrogen peroxide).
- We checked a range of equipment and found it was mostly accessible, clean and well maintained. Resuscitation equipment was regularly checked to ensure that it was fit for use. We heard from a member of medical staff that on one occasion recently they had not been able to locate ventilation equipment for a patient in the resuscitation area. The equipment had been used for a patient the previous day and had gone with the patient to the ward and had not been returned. Nursing staff had been able to locate a machine from elsewhere on this occasion and no harm had resulted. We were unable to establish whether this equipment

was in short supply. We witnessed staff searching for approximately 10 minutes for a child blood pressure cuff which was needed for a child coming to the resuscitation area. The situation was resolved by moving a children's vital signs monitor into the resuscitation bay.

- Regular equipment audits were carried out to check that patient equipment was maintained, clean and fit for use. In July 2015 the ED scored 86% in this audit.

## Medicines (includes medical gases and contrast media)

- Medicines were mostly appropriately stored in locked cupboards or fridges. However, we found on one occasion that the medicines cupboard in the children's ED was unlocked. This was brought to the attention of staff. Fridge temperatures were regularly checked and they were correct at the time of our visits.
- Controlled drugs were appropriately stored and suitable records were kept. Controlled drugs are medicines which require extra checks and special storage arrangements because of their potential for misuse.
- In CQC's 2014 A&E survey the trust scored 9.2 out of 10 in response to the question which asked whether that the purpose of new medicines was explained before patients left A&E. However, the trust scored only 4.7 out of 10 in response to the question which asked if they were told about possible side effects of medicines for those prescribed new medicines while in A&E.
- Some Emergency Nurse Practitioners (ENPS) were trained as non-medical prescribers so that they could supply and administer certain medicines. There were also Patient Group Directions (PGDs) in place. PGDs are agreements which allow some registered nurses to supply or administer certain medicines to a pre-defined group of patients without them having to see a doctor. There was a policy to support the use of PGDs. At Chippenham Hospital we saw evidence that staff had been appropriately assessed and signed off as competent to use PGDs. However, the sign off process in ED was inconsistent and some PGDs had not been signed.

## Records

# Urgent and emergency services

- Patient records were accessible, both electronic and paper versions. Records were stored securely. Electronic patient records were password controlled and paper records on the observation unit were stored in locked trollies.
- We looked at a sample of electronic and paper patient records in each department. They were mostly clear and complete; however we found a few omissions:
  - On the observation unit during an unannounced visit we saw that two patients had incomplete paper records. Each patient was supposed to have an observation unit 'patient passport' completed on admission. One patient who had been transferred from another ward had not had this completed after 24 hours on the ward. Another patient's records were incomplete. In particular, we noted, their DNAR (do not attempt resuscitation) status and allergy status had not been completed. Their falls risk assessment was incomplete and their medical history had not been completed.
  - In ED we found:
    - An observation chart which did not have the patient's name recorded.
    - A triage record where intravenous fluid had been recorded but the time administered was not recorded
    - A patient was administered morphine but the amount was not recorded
- Observation charts were paper records which stayed with the patient. Nurses told us that the paperwork used in ED was generic and not suitable for the ED. Neurological observations were completed on a separate form. We were told that the matron was trying to have this paperwork changed and was awaiting a decision.
- There were formal annual records audits in addition to ad hoc spot checks. Staff confirmed that any deficiencies highlighted in their record keeping during spot checks would be fed back to them individually.
- The electronic patient record prompted staff to consider safeguarding in their assessment of each patient. We looked at a random sample of patient records and saw that safeguarding assessments were consistently completed.
- There were processes in place for the identification and management of children at risk of abuse:
  - Ninety-one percent of senior medical staff had received level 2 child protection training and 63% had received level 3 training. 77% of nursing staff had been trained to level 2 and 45% to level 3. The department was aiming for all clinical staff to be trained to level 3 by April 2016.
  - The patient record system identified previous child attendances in the last 12 months so that staff would be alerted to possible safeguarding issues.
  - Frequent attenders (more than three attendances in last year with different conditions) were discussed with the paediatric team.
  - The ED had access to a senior paediatric opinion 24 hours a day for child welfare issues.
  - All skull or long bone fractures in children under one year were discussed with a senior paediatric or ED doctor during their ED attendance.
  - There was an appropriate 'safety net' to ensure that child safeguarding referral rates were appropriate. The clinical lead for children audited 10 children's records per week.
  - Child attendances were notified to GPs and to health visitors and school nurses if they met referral criteria which were set out in an information sharing form.
  - There were arrangements in place to safeguard women or children with, or at risk of, Female Genital Mutilation (FGM) guidelines and checklists had been produced by the ED's children's safeguarding lead.

## Mandatory training

- We could not be assured that all ED staff were up-to-date with training in safe systems, processes and practices. Compliance with mandatory training was variable, with medical staff being the worst performing staff group. Compliance was particularly poor in infection control, with only 51% and 67% of medical and nursing staff being up-to-date. Fire safety training also showed shortfalls, with only 62% of medical staff and nursing staff having undertaken recent training. In the General Medical Council (GMC) training survey (2015)

## Safeguarding

- Staff understood their responsibilities and they were aware of safeguarding policies and procedures. There was a safeguarding lead nurse in the ED.

# Urgent and emergency services

emergency medicine scored below the national average for induction. Training records showed that only 74% of medical staff had received local induction training. We were told that all incoming junior medical staff attended a two day induction before starting work in the department.

- Compliance with mandatory training for MIU staff was good.

## Assessing and responding to patient risk

- In the ED there was a triage protocol in place for the initial assessment of all patients, although this consisted only of a flow chart and was not supported by a policy which described the process. In the ED the Swindon triage system was used to stream patients according to the severity of their presenting condition. The flow chart showed triggers which would indicate the need for immediate treatment, urgent treatment (less than 30 minutes) and identify those patients who could wait to be seen in order of arrival. Guidance issued by the Royal College of Emergency Medicine (Triage Position Statement, April 2011) states that a rapid assessment should be made to identify or rule out life/limb threatening conditions to ensure patient safety. This should be a face-to-face encounter which should occur within 15 minutes of arrival or registration and assessment should be carried out by a trained clinician. This ensures that patients are streamed or directed to the appropriate part of the department and the appropriate clinician. It also ensures that serious or life threatening conditions are identified or ruled out so that the appropriate care pathway is selected.
- The median time to assessment of patients who arrived by ambulance ranged from nine to 18 minutes between April and September 2015.
- Triage times for self-presenting patients were not routinely monitored or reported on and we had difficulty obtaining performance data from the trust. The median time to assessment for self-presenting patients ranged from 15 to 17 minutes between April and September 2015. However, during our visit we frequently observed waiting times for assessment to be between 30 and 50 minutes in ED. Staff told us patients frequently waited longer than this. They said it was not unusual for patients to wait an hour for assessment.
- We did not witness the triage nurse survey the waiting area when they entered it and the layout and seating arrangement did not make this easy.
- Receptionists told us they were experienced to recognise a seriously unwell/injured patient who needed immediate clinical attention and they told us they would physically summon immediate assistance from clinical staff. However, there was no written guidance and they had received no formal training to recognise 'red flag' presentations as defined by the Royal College of Emergency Medicine in its Triage Position Statement 2011.
- Patients (adults and children) were not adequately observed in the waiting room as recommended Health Building Note (HBN) 15-01 which states "the waiting area should be provided to maintain observation by staff..."
- In the MIUs triage or initial assessment as it was known, was undertaken by a registered nurse or, on occasions, by a healthcare assistant. The initial assessment entailed the recording of the patient's presenting complaint and the time at which they had sustained their injury or become unwell. Allergies and tetanus status and a pain assessment were recorded. Pain relief was offered as appropriate. This process was not described in a standing operating procedure, protocol or policy. Staff told us there was no formal training in respect of triage. Unregistered staff had no guidance in respect of red flag conditions where assistance from a registered nurse should be sought. We were assured that healthcare assistants were experienced and closely supervised by registered nurses, who were always close by. We were satisfied that this was the case during our visits but could not be assured that this was consistently the case, particularly when the departments were busy and/or short staffed.
- Risk assessment of patients presenting with mental health issues was carried out using a recognised mental health assessment matrix, although we noted that two different versions of this document were available and we were told that there was a third which could not be located. There was an observation chart used by staff in the observation unit which set out the level of observations required for patients, according to their risk status. These were consistently completed during our visit; however there were not a high number of

# Urgent and emergency services

mental health patients admitted and none were assessed as high risk. A staff member told us it was not always possible to maintain the required levels of observations when there were numerous medium to high risk patients on the ward.

- As referred to under 'Incidents' (above), we found one patient on the observation unit had not had a comprehensive risk assessment completed in respect of falls, despite the fact that staff had been informed on their admission that they were at risk. A mobility assessment for this patient was not undertaken until 24 hours following their admission. It had been recorded on their observation chart during their first night on the ward that they had tried to climb out of bed. There were no management plans in place to reduce the risk of them falling and the nurse we spoke with was unaware that they had attempted to climb out of bed.
- The trust used recognised early warning tools used for adults (National Early Warning Scores -NEWS) and children (Paediatric Early Warning Scores - PEWS). The triage protocol stated that all patients nursed in majors should have observations taken at least every 30 minutes. At a staff meeting held in August 2015 it was noted that the documentation of observations was being audited. It was noted that recording was not always completed. We asked about these audits during our inspection. The matron told us that audits had not taken place.
- We looked at a random sample of observation charts. They were not consistently completed and we could not be assured that they took place frequently enough. This was particularly the case during our unannounced visit in the afternoon/evening when the department was busy and under-staffed. Examples included:
  - We saw one patient, who was admitted with a severe headache and nausea. Observations were taken shortly after their arrival but did not include neurological observations. Further observations were not recorded until two hours later.
  - A second patient, who was admitted with a headache and shortness of breath, had observations undertaken at triage thirty minutes after their arrival. We checked their observation chart three hours later and no further observations had been recorded.

- A third patient with breathing difficulties was not assessed for one hour after their arrival and then had a second and a third set of observations undertaken an hour and a half apart.
- A fourth patient who was admitted at 3.40 pm following a collapse had observations recorded on arrival but no further observations were recorded until 7pm.
- We could not always locate the observation charts for patients so we could not be fully assured that regular observations were taking place for these patients.
- Following our inspection we advised the trust of our concerns that observations were not being undertaken consistently with the required frequency and that this was not being regularly monitored. They assured us that further audit was to commence in December 2015 and in the meantime the requirements relating to observations would be reinforced with staff.

## Nursing staffing

- We could not be assured that departments were consistently staffed with appropriate numbers of suitably skilled and experienced staff to ensure that people received safe care and treatment at all times.
- We were told that ED staffing levels were established in 2012/13. The trust did not explain the review process and how staffing levels had been reviewed since in the context of increased demand for the service and increasing acuity of patients. Following our inspection the trust confirmed that staffing levels had been reviewed in 2013 using benchmarked information from other local trusts. In 2014 staffing levels were reviewed to take into account the establishment of a dedicated children's ED. A further review took place in February 2015 against the draft guidance, Safer Staffing published by the National Institute for Health and Care Excellence (NICE). However, the status of this review was unclear and a proposal to achieve the recommended staffing levels was not provided.
- Staffing was described as "flexible" with staff regularly moved around within the department and the hospital to support the department as required. There was no overarching document, such as a standing operating procedure which outlined the minimum safe staffing levels and skill mix in the department and how and when these should be reviewed and amended to meet

# Urgent and emergency services

fluctuating demand. The trust told us that additional temporary staff were supplied to support the department at times of pressure. They directed us action cards which outlined the role of the nurse coordinator or senior nurse in each area of the department. These described the responsibility of the nurse coordinator to re direct staff, according to the needs of the department and to escalate when compliance with the four hour target was threatened or breached. It did not define safe staffing levels or describe how these were to be maintained at times of a surge in activity.

- The ED had a number of nurse vacancies (12.6% vacancy rate as at August 2015) and was unable to consistently staff the department to planned levels. Bank and agency staff were regularly deployed and existing staff worked extra shifts to cover shortfalls in the rota and staff were moved around, according to their skills and experience. Despite this, there remained a number of shifts each week which remained unfilled. During August, September and October 2015 the percentage of shifts that were filled was 92%, 96% and 93% respectively. Staff told us that they “struggled” when shifts were unfilled. Several staff talked about the department being “overwhelmed” when staff shortages combined with surges in demand.
- We were told that staffing could be increased at busy times. Patients waiting for admission to a ward sometimes queued in the corridor or in the sub waiting room. Although there was no staff allocation to accommodate this situation, we were told by the matron that the department could safely manage this situation within the existing staff allocation until the number of waiting patients reached 10 (five in the corridor and five in the sub waiting room). This was not supported by a risk assessment or protocol to ensure safe staffing levels were maintained in the corridor. We were told that when waiting patients reached the trigger number of 10, the situation would be escalated to the site management team, and additional staff would be sought from other areas of the hospital.
- Staffing levels were also a concern in the MIUs. Vacancy rates as at June 2015 were 11.5% at Chippenham and 12.8% at Trowbridge Community Hospitals. The lead nurse for MIU told us that it was difficult to recruit experienced nurses to MIU. The skill mix was of concern due to a number of experienced nurses retiring and being replaced by inexperienced nurses who required more support. A staff member at Trowbridge told us that at night, there were often inexperienced staff on duty and they felt vulnerable.
- Staff at Chippenham MIU told us that staffing was “a challenge”, although vacant shifts were usually filled with bank and agency staff or by staff working additional shifts. There were similar challenges at Trowbridge Hospital, where there was frequent and regular use of temporary staff, although most of these staff worked in the department regularly. Both of the MIUs were fully staffed when we visited. However, at Trowbridge Hospital we were told that on Sunday 4 October 2015 the department was “desperately short staffed”. An incident report completed by MIU lead nurse confirmed that the department was short staffed all day due to short notice sickness. They reported that staff were stressed, there were five breaches of the four hour target and delays and mistakes in inputting data in to the electronic patient records system.
- The employment of agency workers was guided by the Non-Medical Agency Worker Local Induction Policy (April 2015). There was an agency worker checklist submitted for each agency worker. This verified details such as their right to work in the UK, health status, registration with professional bodies and training in basic life support and manual handling and department specific competencies.
- There was a guide for agency workers and bank staff which included an induction checklist which had to be completed by the staff member before starting their first shift. This included orientation of the department and a guide to safety systems and protocols.
- There was not a dedicated paediatric trained workforce in ED. The trust confirmed that they had struggled to recruit registered children’s nurses. The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency Care Settings (2012) identifies that there should always be registered children’s nurses in ED or trusts should be working towards this. There were 3.68 whole time equivalent (WTE) registered children’s nurses employed in ED. This meant that the department was unable to ensure there was always a children’s nurse on duty. We were told that the children’s department was sometimes closed at

# Urgent and emergency services

night, pending the recruitment of further children's nurses and the roll out of training for adult trained staff. In the meantime, children who attended at night were seen in the adults' department.

- The RCPCH states that staff should, as a minimum, be trained in paediatric life support (PLS). The trust confirmed that 87% of nursing staff in ED were trained in PLS and a further training session was scheduled in December 2015.
- The unscheduled care division risk register recorded the "potential risk of unnecessary delay for children attending the paediatric emergency department". It was recorded that there was a lack of registered nurses with appropriate skills to support timely initial assessment. The action plan recorded that a band 5 nurse vacancy had been re-advertised. The trust advised us that recruitment activity was continuous and ongoing.
- We were told that the children's department should be staffed by two registered nurses during the day. The duty roster appeared to confirm that this was mostly achieved; however on a number of occasions during our visit we found the department was staffed by only one nurse, even though the allocation showed two nurses were rostered. One day we visited three times and on each occasion we found only one nurse working there. In two occasions we waited 10 minutes before a nurse was visible because they were undertaking assessments in closed cubicles. We were concerned that it would be difficult for an anxious parent to locate a nurse at times.
- One nurse told us that they worked single-handed in the children's department on approximately one in four shifts. They told us if they were worried they would speak with the nurse coordinator in the main department. Another nurse told us they often worked a whole shift on their own and sometimes saw up to 60 patients during that shift. During one day of our inspection the department was staffed by a newly qualified children's nurse, supported by an adult-trained nurse who told us they had little experience of caring for children. During our unannounced inspection the children's department was staffed by two children's nurses, although from time to time one of them was asked to support the adults' department and one of them covered a staff break in the observation unit. The staff duty roster showed that only one nurse was allocated to the children's' department on two day shifts earlier that week.
- Following our inspection we asked the trust to confirm how frequently the children's ED was not fully staffed. They confirmed that in the previous three months there had been 28 occasions (nine day shifts, one night shift and 18 day and nights shifts) when the department was staffed by only one registered nurse. They told us that on these occasions support would be provided by staff working in the minors department. There was also a named doctor allocated to the children's ED. There was work ongoing to monitor attendance patterns of children so that staffing could be organised accordingly.
- The ED was taking steps to mitigate the risk. They had introduced in house training for adult-trained registered nurses to gain heightened awareness of common conditions in children presenting in the department. Nine adult-trained nurses had received this training and further training was planned in January 2016. There were plans to rotate staff from the hospital's paediatric department but this had not yet been possible due to unsuccessful recruitment.
- Children cared for in the resuscitation bay were not nursed by a registered children's' nurse. We were told that doctors from the children's ward attended but were not supported by a children's' nurse and the nurses in the children's ED could not be moved. We were told by the senior nurse in the children's' ED that when they were on duty they would try to support nurses in the resuscitation bay if they were able to be back-filled in their department. We witnessed one occasion when a child was being cared for in the resuscitation bay by an adult-trained nurse. The nurse told us they felt very nervous and scared when looking after children. They confirmed to us they had not received specialist training to care for children. They told us about one recent occasion when they had cared for six children in the minors department because the children's' ED was closed.
- The observation unit was not always adequately staffed. The ward's staffing establishment was one registered nurse, supported by one healthcare assistant (HCA). We were told that if there were patients admitted with mental health needs who had been assessed as high

# Urgent and emergency services

risk and required close supervision, additional staff would be requested. We were told that registered mental health nurses (RMNs) could be provided in these cases; however, two staff told us that they rarely had the support of a suitably qualified nurse. The trust confirmed that in the previous three months six out of fourteen requests for a registered mental health nurse had not been filled. Patients assessed as high risk were those who had “clear plans to engage in self-harming behaviour or to harm others”, whose “mental state will deteriorate rapidly and dangerously without immediate intervention and will be physically vulnerable.”

- Staff on the observation unit told us that they relied on support from the co-located surgical assessment unit (SAU) staff. A staff member told us they felt “lost if the SAU nurse is not around.” Staff told us it was difficult to complete frequent observations on multiple patients, given the staffing numbers. They told us they did observations as often as they could. They were concerned that other patients received less attention because of this. A member of staff from the SAU told us that sometimes staff from the observation unit were moved to assist in ED, leaving them to care for patients on the observation unit, although we did not find any evidence of this. They told us that they provided cover for breaks and “kept an eye on patients” in the observation unit. During our visit we arrived on the observation unit while the registered nurse was taking their lunch break. We were told this by the HCA but it transpired that the SAU nurse did not know that their colleague had left the ward. We fed this back to the matron and when we returned for our unannounced visit they told us that nurses’ breaks in the observation unit were now being covered by ED staff.
- It was reported at a staff meeting in March 2015 that an internal staff survey had revealed that “a shocking number of staff” had dealt with verbal or physical abuse from patients and relatives and had concerns for their safety and the safety of patients. Additional training in conflict resolution was being provided. Two staff working on the observation unit told us they did not like working there as they felt vulnerable due to the unpredictable nature of some patients with mental health needs. They told us about patients who had thrown drip stands and chairs and patients who had attempted to hang themselves and cut themselves. Staff reported that other patients on the ward felt unsafe, particularly older people and vulnerable patients. We spoke with one such patient who told us they felt scared at times.
- The trust confirmed that 16 incidents were reported by staff on the ED observation unit in the last six months relating to the management of mental health patients.
- Staff told us that they had received training in de-escalation techniques; some had received advanced conflict resolution training which they had found helpful. However, they told us they had received no training or guidance in how to make the environment safe for people who were at risk of self-harming. One nurse told us “we just take everything away from them.” We asked the trust if they had undertaken ward-based or individual patient risk assessments in relation to ligature risks. They sent us a draft Close Observation of Patients Policy. Although this policy was in draft, we were told that it reflected current practice. None of the staff we spoke with on the observation unit were aware of this policy and the checklists which formed part of this policy were not in use.
- The risk register recorded that there was “a lack of educational support to the nursing team, to ensure they have the necessary data to nurse mental health patients.” The Liaison Consultant Psychiatrist told us that teaching sessions were being provided for nurses and medical staff but nurses we spoke with on the observation unit had not received any specialist training, although they understood that this was planned. Following our inspection we asked the trust to confirm the current position in relation to this. They confirmed that a small proportion of nursing staff (nine staff) had attended training to date and further training was scheduled for ED staff in January 2015.
- Security staff told us that they were frequently called to support staff in the observation unit. Patients who had self-harmed or who were assessed as being at risk of harming themselves or others were not permitted to leave the locked ward (for fresh air or for a cigarette for example), without an escort. We were told that the staffing levels sometimes did not allow for this and security staff were called to assist in these circumstances and to search for patients who had absconded. Security staff also raised concerns about the number of occasions that patients were subject to a

# Urgent and emergency services

temporary section under the Mental Health Act 2005 (section 5(2)), which they were called to assist with. The trust confirmed that a total of nine patients were subject to this form of detention from September 2014 to September 2015.

- We were told about an incident which occurred on 27 September 2015 when the ED was three staff short for the night shift due to short notice sickness. Nursing staff from the observation unit were moved to the ED and the observation unit was closed. However due to bed pressures within the hospital overnight, the decision was made to re-open the observation unit. Six patients were transferred there from the Acute Medical Unit (AMU). One of these patients told us about their experience. They told us that patients did not get the attention they required. One patient, who was living with dementia, was not properly supervised and had to be assisted by a fellow patient. They told us some patients did not receive their medicines. The unit was staffed by a healthcare assistant (HCA) only between 11pm and 3am. Although this staff member was supported by a registered nurse in the co-located SAU, the SAU staff were busy and the HCA felt the situation was unsafe. The HCA reported this event as an untoward incident. They reported that patients' medicines were delayed, including pain relief, causing distress to patients. Following this incident the trust assured us that steps had been taken to prevent this happening again, including the ED and SAU managers working cooperatively to ensure the co-located areas supported each other and cross covered work appropriately.
- During our unannounced visit, staff made us aware of a further recent incident on the observation unit where a patient experiencing a psychotic episode had punched another patient in the face. The incident was still under investigation during our visit but it was confirmed that a registered mental health nurse had been requested to provide close observation of this patient but they had not turned up for their shift. It was recorded in the patient's notes that when staff raised concerns they were told that the HCA would have to provide one to one supervision of this patient. This meant the registered nurse had no support to care for the remaining seven patients. Another agency nurse was subsequently deployed and it was during their handover that the assault occurred. The trust confirmed

that an investigation had taken place and that the incident was to be discussed at a forthcoming security advisory group to identify any learning from this incident.

- Following our inspection we drew our concerns to the attention of the trust. They advised that in response to our concerns they had arranged a meeting to develop plans to mitigate ligature risk, including the development of guidance and training for ligature risk assessment and monitoring.
- The MIUs were not fully staffed. Vacancy rates as at June 2015 were 11.5% (Chippenham) and 12.8% (Trowbridge). Staff told us that they were regularly asked to work extra shifts. Bank and agency staff were also regularly employed. We were told that the MIUs occasionally closed due to staffing difficulties. This had occurred five times at Trowbridge and once at Chippenham in the last 12 months, although on the last occasion the closure was due to staffing difficulties elsewhere in the trust.

## Medical staffing

- The ED was almost fully staffed (1% vacancy rate as at June 2015). There was consultant presence 14 hours a day (8am to 10pm) and there was always a minimum of an ST4 (specialist registrar year 3) or above in the department, supported by a consultant on call, 24 hours a day, seven days a week. Junior medical staff and nursing staff told us that they were happy with the level of consultant and senior medical staff cover.
- Locum staff were used infrequently. There were no locum staff employed during our visit; however we saw there was a system in place to ensure locum staff were properly vetted and inducted. There was a guide for locum medical staff, which included a checklist, which had to be completed by the staff member before completing their first shift. Orientation and assessments were completed by supervising medical staff, which included an identification of any training needs.
- There were structured medical staff handovers at the start of each shift, led by the consultant in charge. A checklist was used to ensure that all important safety matters were discussed. All patients in the department and their plan of care were discussed. Any risks and challenges were discussed, including waiting times and the hospital's bed state. We observed several handovers

# Urgent and emergency services

during our visit and we were impressed with the level of engagement of all medical staff. However a nurse did not attend consistently, was not always engaged and had little input.

- There was a consultant who was dual trained in adult/ paediatric emergency medicine.
- Medical staff had received appropriate levels of life support training for children.

## Other Staffing

- Porters were deployed in the ED 24 hours a day, seven days a week. We were told by portering staff that eight staff should be deployed in the hospital on staggered shifts throughout the 24 hour period but this was rarely achieved. They told us there were usually between four and six staff available. Nursing staff told us that the portering service was often inadequate at busy times and that doctors, nurses and managers were used to transfer patients. We observed the clinical site manager transferring a patient to a ward because a porter was not available and the department was becoming full.

## Major incident awareness and training

- The trust provided us with a draft incident response plan (July 2014) which set out the processes for responding to a range of incidents, including major incidents which cause or have the potential to cause severe disruption to the service and/or serious threat to the health of the community. There were a series of action cards for each service and roles within that service. This plan was ratified during the course of our inspection and the trust told us it was currently working on the training and exercise plan to embed this. A full major incident exercise was due to take place in the spring of 2016, although we were told that a small table top exercise had recently taken place to “sense check” the plan.
- Within the incident response plan there were action cards setting out responsibilities and protocols for decontaminating patients who have been in contact with hazardous materials. The unscheduled care division risk register recorded a “risk of staff and patient harm as a result of chemical, biological, radiological and nuclear (CRBN) preparedness arrangements being incomplete or out of date. It stated that there was “a lack of assurance that the trust will be able to respond

effectively to a CRBN incident.” Decontamination equipment was in place, including a decontamination tent and showers. Training sessions had taken place but not all staff had received this training and there were varied levels of staff awareness and familiarity with processes and equipment.

- In January 2015 a patient with suspected Ebola (later confirmed as negative) was admitted to ED. A debrief report outlining the lessons learned from the management of this case was published in February 2015. The Ebola Plan was subsequently updated in April 2015. Action cards for staff were available in the ED.
- There were security staff employed in the hospital, although they were not based in ED. The matron told us they had requested more security support for the observation unit. There was a panic alarm located at the nurses’ station in the observation unit and this sounded in the ED when activated. The matron did not think this was adequate because of the distance from ED to the observation unit and the time it would take to respond. Staff did not consistently carry personal alarms in accordance with hospital policy. During our unannounced visit only one staff member out of 12 we asked, was wearing an alarm. Eight of these staff had not been issued with alarms, despite some of them requesting repeatedly.

## Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement



There were recognised national clinical guidelines in place but evidence to show that these guidelines were complied with or that people received good outcomes was limited. The service participated in national audits to benchmark its practice but audits were not seen as a priority and improvement actions were not always completed promptly. There was enthusiasm for participation in research, with a number of successful clinical trials ongoing. Junior medical staff were well supervised, felt well

# Urgent and emergency services

supported by their seniors and received regular teaching. However, nurse education did not take place in a structured or consistent way and we could not be assured that all nurses were able to regularly update their skills.

The service worked well with other teams and services so that people received coordinated and seamless care.

## Evidence-based care and treatment

- Care and treatment was delivered using clinical guidelines, for example, National Institute for Health and Care Excellence (NICE) guidelines and the Royal College of Emergency Medicine's (RCEM's) Clinical Standards for Emergency Departments. Guidelines were available via the intranet, although some links were broken, were mainly generic and had not been adapted locally. We found three different versions of guidelines for assessing patients with mental health needs.
- We saw good awareness and engagement with the sepsis protocol which was clear and well displayed in the emergency department (ED) and which was discussed at junior doctor induction training.
- There was a clear pathway for patients who presented with a stroke and we saw this followed efficiently during our visit.
- There were no clinical guidelines available for Emergency Nurse Practitioners (ENPs) in ED. We were told by the matron that they were currently being updated to ensure that they were current and evidence-based.
- Six out of the 10 ENPS employed in ED were not qualified as non-medical prescribers and they had no Patient Group Directions (PGDs) to allow them to prescribe certain medicines to patients. This meant that they had to request doctors with prescribing rights to prescribe medicines for patients who they had not seen.
- There was guidance specifying which patient groups or conditions could be treated in the minor injury units (MIUs) and those which required transfer to the ED.
- Patients told us they received pain relief when they needed it. We saw that this was mostly the case; however, there were some notable exceptions.
- The ED participated in the RCEM 2012-13 renal colic audit 2012. The trust scored in the upper quartile nationally for the recording of a pain score, although the RCEM standard was not met. The trust scored in the median and upper quartiles for the provision of prompt pain relief for severe pain, although RCEM standards were not met. The trust scored in the lower and median quartiles for the provision of pain relief for patients in moderate pain.
- The ED participated in the 2012-13 RCEM audit of fractured neck of femur (hip fracture). Hip fractures are painful and the administration of pain relief should be a priority in the ED. The trust scores were in the median or upper quartiles for the prompt provision of pain relief for moderate and severe pain, although the RCEM standards were not met, showing room for improvement. Pain scores were recorded for only 68% of patients. We were provided with no evidence to show that action had been taken since this audit to improve performance.
- During our unannounced visit we followed the progress of a patient (an older person living with dementia) who had been brought into ED by ambulance with hip pain. They were triaged 24 minutes after their arrival. A pain score was not recorded and pain relief was not given. We reviewed this patient's notes two hours and forty minutes after their arrival. Their relative told us they were in pain but they had received no further observations since their triage and there was still no pain score recorded or pain relief given. The patient had been x-rayed and at 8.20pm it was confirmed that they had fractured their hip. They were then given appropriate pain relief three hours and forty minutes after their arrival. We drew this to the attention of the consultant in charge. They were surprised that the hip fracture pathway had not been followed. The pathway prompts clinicians to assess and record pain and offer appropriate pain relief. The consultant later confirmed to us that the pathway had not been followed because a pelvic fracture (pubic rami) was suspected. However this explanation did not alter our concern that pain was not promptly or regularly assessed. We noted that the hip fracture pathway was a paper-based pro forma to be

## Pain relief

- In the CQC 2014 A&E survey the trust scored 7.3 out of 10 for the question about whether staff did everything they could to control their pain. This was about the same as other trusts.

# Urgent and emergency services

completed by clinicians. It had not been transferred to the electronic-based patient record system. We were concerned that the lack of prompts and documentation may reduce compliance with the pathway and make it more difficult to audit.

- We reviewed the records of another patient who attended ED on the evening of our unannounced inspection. They arrived at 7.56pm, presenting with cholecystitis (gall stones). A pain score of 10 (severe) was recorded but they were not given morphine until one hour and nine minutes later.
- It was reported at a clinical governance meeting in May 2015 that, following a study performed by medical students of the management of pain in patients following a femoral nerve block (used to relieve pain in leg fractures), stickers had been introduced to be affixed to patients' notes to remind staff to review pain relief more, although we did not see these in use.

## Nutrition and hydration

- There were two hourly drinks round undertaken by healthcare assistants and we saw these taking place during our announced visits. We did not see these take place during our unannounced visit when the department was busier, although a number of patients confirmed they had been given drinks when they asked. Drinking water was available on request once patients had been examined.
- In the CQC 2014 A&E survey the trust scored 6.3 out of 10 for the question about whether they were able to get suitable food or drinks when they were in the A&E department. This was about the same as other trusts.

## Patient outcomes

- Information about patient outcomes was routinely collected and monitored. The trust participated in national Royal College of Emergency Medicine (RCEM) audits so they could benchmark their practice and performance against best practice against other EDs. The audit lead told us that funding for participation in RCEM audits in the current financial year had not yet been released due to the trust's financial difficulties. However, we were later informed by the trust that funding had been made available and that the trust had registered with the RCEM to participate in the forthcoming year's audits.

- In the RCEM 2013-14 audit of severe sepsis and septic shock there was variable performance. The trust scored in the lower national quartile for four indicators, in the average quartile for five indicators and in the upper quartile for three indicators. Areas for improvement were: the measurement and recording of vital signs within 15 minutes of arrival, measurement and recording of blood glucose and measurement of urine output. Quarterly audits of compliance with the sepsis 6 pathway (a set of interventions to be undertaken within the first hour of sepsis presentation) took place. A baseline audit undertaken in July 2014 reported poor compliance. Actions arising from this audit included staff education and training and meetings with neighbouring trusts. In the most recent audit (January to March 2015) there was significant improvement:
  - 98% of patients had the sepsis pathway completed
  - 82% of patients had lactate measured within one hour of arrival
  - 52% of patients had antibiotics administered within one hour
  - Mortality rates were consistently below the national predicted levels in quarters 1, 2 and 3. Mortality rates for quarter 4 were not known at the time the audit report was published.
- In the 2014/15 RCEM audit of initial management of the fitting child the trust performed in the upper quartile for four out of five indicators, compared with other English trusts.
- In the 2013/14 asthma in children audit the trust's performance was variable, with room for improvement identified. An action plan was shared with us; however progress and/or completion of actions were not recorded so we could not be assured that learning had taken place.
- In the 2014/15 mental health in the ED audit the trust performed in the upper quartile for five out of the nine indicators and in the lower quartile for two out of the nine indicators compared to all England trusts. An incomplete action plan was shared with us.
- In the 2013/14 paracetamol overdose audit the trust's performance was variable. Again, an incomplete action plan was provided by the trust.
- In the 2014/15 audit: assessing for cognitive impairment in older people the trust's scores were in the upper

# Urgent and emergency services

quartile for four indicators, in the middle quartile for one indicator and in the lower quartile for one indicator. The trust failed to meet the fundamental standard which requires that an early warning score is documented. An action plan was not provided to show how improvements were to be made.

- The unplanned ED re-attendance rate in 2014/15 was better than the England average but generally higher (worse than) the standard of 5%.
- The audit lead for ED told us that performance in national audits was “not great but by no means terrible”. We saw little evidence that actions had been taken to improve performance in areas where shortfalls had been identified.
- The department was participating in a number of clinical trials. There was a lot of enthusiasm and commitment amongst medical staff and many had Good Clinical Practice (GCP) training. GCP is the standard and guidelines to which all research must be conducted.
- There was a system in place to reconcile all radiology diagnosed fractures with patients’ notes. Middle grade doctors were allocated on a rota to review radiology results, to feed back to individual doctors and group teaching sessions on any missed fractures, and to inform patients. There were weekly meetings with radiology to discuss unusual findings or issues. We were told that there was a very low missed fracture rate. It was felt that the accessibility of senior medical staff was the main reason for this success.

## Competent staff

- We could not be assured that nursing staff had the right qualifications, skills, knowledge and experience to do their job. Teaching for nursing staff was described by the matron as ‘ad hoc’ and was an area they wanted to improve. There was no dedicated professional development nurse (as would otherwise be the case in most trauma centres or large EDs).
- A training matrix was provided but contained many unexplained gaps and so did not provide assurance that staff had appropriate and up-to-date competencies.
- The lead nurse in MIU was unable to provide an overview of staff competencies so that we could be

assured that all staff were appropriately skilled. There was no system of formal clinical supervision, although mentoring and informal supervision took place and staff told us they felt supported.

- We were told by the trust that a skills booklet was introduced to all staff in April 2015 so that staff could keep a record of their competencies. We asked a number of staff in ED and the MIUs to show us these. None of the staff we spoke with had been issued with such a booklet.
- There was protected time for medical staff teaching with weekly teaching sessions held in ED for junior and middle grade doctors, in addition to ad hoc ‘shop floor’ teaching. Junior medical staff told us they felt well supported.
- Staff employed in Chippenham MIU were not aware of any opportunities to rotate to a more acute setting to enhance their skills. A staff member at Trowbridge MIU told us that there were limited opportunities for professional development specific to MIU competencies, although we heard from the MIU lead nurse about two training sessions that were planned; one in head injuries and the other relating to domestic violence.
- Staff appraisal rates were as follows:
  - ED registered nurses: 71.6%
  - ED unregistered nurses: 91.3%
  - ED medical staff: 77.7%
  - MIU Chippenham registered and unregistered nurses: 100%
  - MIU Trowbridge registered nurses: 69.2%
  - MIU Trowbridge unregistered nurses: 100%

## Multidisciplinary working

- There was good team working within the ED. Care was delivered in a coordinated way with support from specialist teams and services.
- We saw examples of good multidisciplinary working:
- A “virtual” fracture clinic had been introduced in March 2015. This was an initiative jointly developed by ED and orthopaedics, designed to avoid unnecessary visits to fracture clinic and delayed referral to specialists.

# Urgent and emergency services

Patients who sustained a fracture were telephoned within 72 hours after their x-ray results were received and given advice regarding the management of their injury.

- There were chest pain pathways which had been jointly developed by ED and the trust's cardiac team. Patients were risk rated 'red', 'amber' or green and management plans had been devised which could be implemented even if the team were not on duty in the department.
- We saw an ENP refer a patient to the Ear Nose and Throat clinic for a procedure which they were not confident to perform. The patient was immediately accepted.
- Staff told us there were good relationships with the Acute Medical Unit and the Ambulatory Care Unit. Physicians from the Ambulatory Care Unit visited ED at 8am each morning to identify suitable patients who could be assessed and monitored in a chair-based unit.
- Staff reported good relationships with specialty teams:
  - There were good relationships reported with radiology services. Medical staff in ED told us X-rays were reported within 72 hours, and CT scans within the hour, although no evidence was provided to support this. Weekly meetings with radiology took place to promote this good working relationship
  - There were regular meetings with the mental health liaison team and staff in ED and the observation unit reported a good working relationship. There was an operational mental health group whose purpose was to provide a forum for identification and resolution of ongoing operational and interface issues and problems relating to the provision of mental health care within the acute hospital. In addition, the Mental Health Liaison Team Manager met regularly with the ED mental health nurse and ED consultant to identify and resolve operational and care pathway issues. The two services had worked together to review the management of frequent attenders to the department and had produced anticipatory care plans for these patients. The mental health liaison team had introduced awards to hospital staff who cared for people with mental health needs. A staff member in the observation unit had recently been recognised for "going the extra mile" in their care of patients with mental health needs.
- Paramedics from the local ambulance service told us there was a good working relationship between the two services.
- Staff reported there was a good working relationship with the urgent care centre but we found there was confusion about the acceptance criteria.
- X-ray services in the community hospital were run by a local acute hospital trust. MIU staff reported good working relationships with radiographers, with whom they could discuss results. They could also contact radiology and orthopaedics staff at the acute hospital for advice.
- MIU staff reported a good working relationship with out of hours (OOH) GP services, and frequently "helped each other out" although a staff member told us they "wasted a lot of time" ringing the central call hub to make referrals. We saw two examples of excellent cooperation between MIU staff and OOH GPs during our visit to Trowbridge MIU on a Sunday. Staff had concerns about a wheezy child and arranged an appointment for the child to see the GP on duty without delay. Similarly a nurse was concerned about a patient who was feeling very unwell. They arranged a prompt appointment for the patient to be seen by the GP. Whilst waiting for this, they also took advice from the local acute hospital's on call physician and, following this and a brief discussion with the GP, arranged for the patient to attend the ED at the local acute hospital. Staff also reported a good working relationship with GP surgeries. During normal working hours, staff were able to make urgent appointments for patients who presented at MIU with minor illness.
- In one of the MIUs a staff member reported that the relationship between them and ED sometimes became strained because there was a perception that they referred patients unnecessarily. There were no jointly produced protocols, pathways or evidence of joint working.

## Seven-day services

- There was senior medical staff presence in the ED seven days a week.
- Radiology was available seven days a week at Great Western Hospital. X-ray was available at Chippenham and Trowbridge Community Hospitals from Monday to

# Urgent and emergency services

Friday only, with some availability during bank holidays. This meant that patients had to travel to another centre or return on Monday. Staff told us that Mondays were very busy as a result.

- The mental health liaison team was available seven days a week, although hours were fewer at weekends.
- Older people with complex needs were not routinely admitted to the observation unit because there was little occupational therapy or front door team assistance at weekends.

## Access to information

- Staff had access to relevant patient information. There was an electronic patient information system which held patients' personal information, such as their next of kin and their family doctor, and details of previous attendances. For new patients this information was entered at the time of arrival. For returning patients, the information was checked and amended as necessary by the receptionist. Patient records generated for each attendance would be pre-populated with this information so that nursing staff were aware of these details when they assessed patients.
- Staff in ED had access to real time information systems which allowed them to view activity in the department as a whole. A large electronic "whiteboard" was located in the central coordinating hub and allowed a clear oversight of ED activity and the ability to track patients' progress, whilst in the department. The electronic patient record allowed the tracking of investigations and treatments whilst in the department. Paper records such as observation charts were scanned by administrative staff. Discharge summaries to GPs were generated electronically.
- Nursing staff had access to digital X-ray facilities. Imaging could either be interpreted by nursing staff on site or could be sent to the neighbouring acute hospital (the provider of the X-ray facilities) for a second opinion.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Training records showed that only 62% of medical staff had received training in consent and the Mental Capacity Act 2005, while the majority of nurses had received this training. Doctors told us that if they had

any doubts about a patient's capacity to consent to care and treatment they would refer to guidelines on the intranet or seek senior advice which, they said was readily available.

- Most decisions required verbal or informal consent.
- Patients told us that doctors and nurses explained things to them in a way that they could understand. We observed staff asking patients' permission to undertake examinations or perform tests.

## Are urgent and emergency services caring?

Good



Feedback we received from patients and visitors was overwhelmingly positive. This feedback was consistent with results from patient satisfaction surveys. All staff-patient interactions that we observed were positive, with observed staff including reception staff, doctors, nurses, porters and housekeeping staff. Patients and their relatives told us they were treated with kindness, compassion, dignity and respect. Patients and their relatives were kept informed and involved in decisions about care and treatment.

Two staff members in the emergency department (ED) were nominated for the People's Choice award in 2015. The patient who nominated them commented on how the staff "...went above and beyond what anyone would expect of them. They are angels."

## Compassionate care

- Patients' privacy and dignity were mostly respected. In CQC's 2014 A&E survey the trust scored, 8.5 out of 10 for the question which asked if people were treated with dignity and respect while they were in the ED.
- Patients received respectful and considerate care. In CQC's A&E survey the trust scored 8.8 out of 10 for the question which asked if staff did not talk in front of them as if they weren't there. We observed that staff introduced themselves and spoke with people politely and respectfully.
- We saw staff taking care to maintain people's privacy and dignity, drawing curtains where appropriate. Signs

# Urgent and emergency services

were used to prevent people entering cubicles when examinations were in progress but we noted that these were not used consistently and we inadvertently walked in on somebody using a bedpan.

- The trust used the friends and family test to capture patient feedback. Results for the ED and the minor injury units (MIUs) were consistently above four (out of five) from April to July 2015, indicating that the majority of respondents would recommend the service to friends and family.
- Two staff members in the emergency department (ED) were nominated for the People's Choice award in 2015. This award was part of the trusts' staff excellence awards. The patient who nominated them said, "I was in ED from 7am to 2pm and all that time X and Y didn't sit down once. They carried on with a smile and were polite to those who were rude to them. They both took the time to comfort me when I was upset. Some people would say they were just doing their job, but personally I think they went above and beyond what anyone would expect of them. They are angels."

## Understanding and involvement of patients and those close to them

- Patients and those close to them were involved as partners in their care. In CQC's 2014 A&E survey the trust scored:
  - 7.4 out of 10 for the question which asked if patients were as involved as much as they wanted to be in decisions about their care and treatment.
  - 7.7 out of 10 for the question which asked patients if the doctor or nurse explained their condition and treatment in a way they could understand.
  - 8.2 out of 10 for the question which asked if the doctor or nurse listened to what they had to say.
  - 6.9 out of 10 for the question which asked patients whether their family or someone else had enough opportunity to talk to a doctor if they wanted to.
- Patients told us they were kept informed about waiting times and staff had apologised and explained if their wait had been long. We observed staff in Trowbridge MIUs explaining to patients how many patients were in front of them in the queue and approximately how long it would take to be seen.

## Emotional support

- In CQC's 2014 A&E survey the trust scored only 5.9% out of 10 for the question about whether patients felt reassured by staff if they were distressed while in A&E and only 6.6 out of 10 in response to the question which asked if they had any anxieties and fears about their condition or treatment, a doctor or nurse discussed these with them.
- A relative told us that they had received "outstanding" emotional support when they received some bad news about their family member's condition. They said: staff went above and beyond to make sure we, as a family, were ok".

## Are urgent and emergency services responsive to people's needs? (for example, to feedback?)

Requires improvement



Services were not always organised and delivered so that patients received the right treatments at the right times. The service did not consistently meet waiting time targets. At busy times departments were overcrowded and patients queued in the corridor. Some patients experienced long waits and there were frequent delays for patients who required admission because there were insufficient beds available in the hospital. These waits and delays impacted on patients' comfort, privacy and dignity.

The emergency department (ED) observation unit frequently accommodated patients who required a medical or surgical specialty bed when no suitable bed was available. These patients were known as 'outliers' and were frequently admitted to the observation unit when the hospital was in escalation. Some patients were not clinically appropriate for this type of ward and their needs were not fully met. These patients were sometimes not reviewed promptly by the most appropriate clinicians. The inappropriate use of the observation unit also meant that the ward was not being utilised effectively for maintaining patient flow.

Patients with mental health needs were not always assessed promptly by a mental health practitioner. These

# Urgent and emergency services

patients also sometimes spent too long on the ED observation unit, which was not a suitable therapeutic environment for their potentially distraught, agitated or suicidal states.

Premises and facilities were not always fit for purpose. Some accommodation was cramped and this was not conducive to the exchange of confidential information.

## Service planning and delivery to meet the needs of local people

- Services were not always available in the right place at the right time to meet the needs of the local population. Many staff expressed frustration that urgent and emergency services were used inappropriately and that better public education was needed to ensure that the public chose the most appropriate care pathway. The Emergency Care Intensive Support Team (ECIST) observed during their visit to ED in May 2015 that 30% of patients who attended the minors' ED were redirected to the urgent care centre but only after they had been checked in and assessed by ED, which was a duplication of effort. They recommended that the trust develop a methodology that streamed patients into urgent care before being checked into ED. This recommendation was part of the trust's service improvement plan.
- The minor injury unit (MIU) at Trowbridge Hospital saw few patients overnight (39 in August 2015) and it was judged that a significant proportion of attendances were inappropriate.
- There was a lack of clarity with regard to the most appropriate pathway for patients who self-presented at ED with a minor injury. For example we observed a patient who was booked in at reception, waited 30 minutes to be seen by a triage nurse and was then re-directed to the urgent care centre. The hospital's website informed patients that the urgent care centre saw patients with minor illness. The matron confirmed this to us and was puzzled as to why the patient was re-directed in this way. We briefly visited the urgent care centre and spoke with a member of staff. We requested a copy of the acceptance criteria for their unit. They were unable to provide this, saying that it was frequently updated. We requested the same from the triage nurse in ED and from the matron and were provided with two different (undated versions).
- The observation unit, although not part of the general hospital bed base, was frequently used to accommodate patients who required an inpatient stay on a medical or surgical ward but beds were not available in the appropriate specialty. These patients were known as outliers. Although ED consultants were the 'gatekeepers' of these beds we were told by ED consultants that admission of outliers sometimes took place without discussion.
- This practice reduced the effectiveness of the observation unit which was designed to avoid unnecessary hospital admissions and allow clinical decisions predicted to take more than four hours and less than 24 hours. ECIST commented on this practice in May 2015. They said; "It is our view that this practice is counterproductive, not in the best interests of patients and should cease."
- We were also concerned that outlier patients may experience delays in their assessment and treatment. One staff member told us that outliers were often "forgotten". Another staff member told us "we are constantly apologising to patients because they wait so long to be seen by their specialty." They told us about a recent surgical (outlier) patient who waited all day until 7pm to be seen by a surgeon.
- During our visit one patient admitted to the observation unit on 27 September 2015, in order to relieve bed pressures elsewhere, was still an inpatient on this unit on 2 October. The patient had complex medical needs and was frustrated and distressed that they were not receiving care and treatment on an appropriate ward. A consultant told us the admission and continuing care and treatment on this ward was "not really clinically appropriate". It was recorded in this patient's notes on the day following their admission: "tried to get hold of medical doctors but nobody was aware of this patient. Spoke to AMU (acute medical unit) consultant who said they would be down to see outliers soon (this was at 10.30 am). They came at 1.45 pm." Another patient (a medical outlier) had been waiting for two days for the results of a diagnostic test.
- During our unannounced visit there were two orthopaedic outlier patients on the observation unit. One patient had been admitted a few days previously to a medical ward and was transferred to the observation unit prior to surgery. A nurse told us they were not sure if

# Urgent and emergency services

they would be returning to the ward post operatively as they did not normally look after post-operative patients. In the event there were no orthopaedic beds available so the patient returned. A second outlier patient had been admitted the day before our visit, following a fall. They were being looked after by the orthopaedic team and they required a period of observation. The patient was elderly and was living with dementia. Nursing and medical staff told us their admission to this ward was inappropriate but we felt that there was a degree of acceptance that this was just the way it was. The patient was confused and agitated and was not able to communicate fully. We drew it to staff's attention that the patient was unable to use their call bell to summon help. We also noted that they could not be easily observed from the nurses' station when the curtains were drawn. Given that this patient was reported to be agitated, was at risk of falls and had tried to climb out of bed, we were concerned about his safety and wellbeing. Following our discussion, the nurse moved the patient to another position in the bay where they could be more easily observed.

- ED/MIU facilities were well signposted and accessible. There was parking available close to the departments, although staff told us that at busy times car parks were not large enough. At Trowbridge Hospital car parking was monitored to prevent inappropriate/unauthorised use. Patients and visitors were asked to use an electronic system to record their car registration numbers.
- Some accommodation was not conducive to the exchange of confidential information. For example, in ED, confidential conversations could be overheard at the reception desk. The ED minors' area was cramped and cubicles were separated only by curtains. In the sub-waiting room in ED majors we observed a nurse interviewing a patient in earshot of other waiting patients.
- In the MIUs, accommodation was adequate but confined in space. The initial assessment of patients took place at the nurses' station, in earshot of other patients in the department. Telephone calls made by nursing staff where patients' personal details were discussed could also be overheard. There were a number of private consultation spaces but these were

often in use. There was no dedicated plaster room so plaster equipment was stored on a trolley and moved to any available room, including the resuscitation room when needed.

- Waiting areas appeared large enough and there was adequate seating to accommodate patients and visitors during our visits; however staff at Chippenham MIU told us that the waiting room often overflowed at busy times and patients waited in the x-ray waiting room along the corridor, which had no natural light.
- Waiting patients and visitors had access to vending machines where they could purchase hot and cold drinks and snacks.
- There were toilets suitable for adults and children and nappy changing facilities. There were areas available for breast feeding mothers.
- There were separate waiting areas for children which were suitably decorated, furnished and equipped. In the ED the waiting room had restricted access and was not overlooked by the adults' waiting area. However, due to staffing constraints the children's ED was not open at night and children waited in the main department alongside adult patients. Health Building Note 15-01 recommends that children have dedicated waiting room rooms so that patient and visitors in the adult area cannot view them. A staff member told us "it is scary for children to sit in the adults' waiting room."
- Patients were given information to make their visit more comfortable and convenient. A TV monitor in the ED waiting room displayed a range of information including information about the hospital's restaurant and car parking. There was a poster guide to staff uniforms in the department, so that patients could identify staff roles, and a guide of the patient journey through the minors department. There was a letter given to medical expected patients who had been referred by their GP for direct admission but who were unable to be admitted due to the unavailability of beds. The letter explained the reason for the delay in their admission and what they should expect.
- In Trowbridge MIU there was a sign at the entrance to the department advising people what the current wait

# Urgent and emergency services

to be seen was. Staff told us they used this when there were waits in excess of an hour. Staff told us that reception staff and nursing staff tried to keep people informed of waits.

## Meeting people's individual needs

- The service took account of individual needs of different patient groups, including those in vulnerable circumstances.
- The departments were accessible for people with limited mobility and people who used a wheelchair. Wheelchairs were available in the departments, including chairs which could accommodate bariatric patients.
- A telephone interpreter service was available for patients/visitors whose first language was not English. There were hearing loops in reception to assist people who were hard of hearing.
- Patients who presented to ED with mental health issues, including those who had self-harmed were usually admitted to the ED observation unit to await assessment by a mental health practitioner.
- A hospital-wide mental health liaison service was provided by the local mental health trust. The standing operating procedure stipulated that the service was available 365 days a year from 9am to 5pm Monday to Friday and from 9am to 1.30pm at weekends, with a minimum of two mental health practitioners on duty at any one time. There were plans to extend the service at weekends to 4pm.
- A service level agreement set out the response time standards advocated by the Royal College of Psychiatrists (2013) against which the service could be measured. The service aimed to respond to emergency referrals within 60 minutes and to urgent referrals within five hours during the same working day. Out of hours access to urgent mental health support was via the intensive service, also provided by the local mental health trust. Staff told us that the mental health liaison team was reasonably responsive, although some delays did occur frequent out of hours because the intensive service was so stretched.
- We requested data to demonstrate how long patients waited for mental health assessment by a mental health practitioner. This showed that between July and September 2015 patients waited on average 11.6 hours, 3.5 and 7.3 hours respectively, which was significantly worse than the standard. Maximum waits for the same period were 172 hours, 31.5 hours and 74 hours. We were concerned that waits of this magnitude in this unsuitable environment would be detrimental to patients' mental health. This also meant the service was not making effective use of observation beds.
- There was an operational mental health group whose purpose was to provide a forum for identification and resolution of ongoing operational and interface issues and problems relating to the provision of mental health care within the acute hospital. In addition, the SOP stated that the Mental Health Liaison Team Manager would meet with the ED mental health nurse and ED consultant once a month to identify and resolve operational and care pathway issues.
- In the 2014/5 Royal College of Emergency Medicine (RCEM) audit of mental health in ED the trust was in the lower quartile nationally for the percentage of patients assessed by a mental health practitioner. The audit also highlighted that there was no dedicated assessment room for mental health patients, as recommended by the psychiatric liaison accreditation scheme and endorsed by the RCEM.
- Staff recognised the importance of supporting bereaved relatives. Deceased patients were moved to a viewing room where family members could spend time with them. There was also an adjacent relatives' room. Both rooms were appropriately and sensitively decorated and furnished.
- There was a designated link nurse to support staff, some of whom had also received training in breaking bad news from the organ donation team. Mortuary and bereavement service staff told us they had received positive feedback from bereaved relatives regarding the care they and their family members had received.
- Alcohol liaison nurses visited the ED and observation unit and patients could be referred to clinics held in the community for support.
- Link nurses had been identified to support staff caring for patients with a learning disability. Their names and photographs were displayed at reception. There was a learning disability nurse who could be called upon to support patients and staff.

# Urgent and emergency services

- Staff described how they supported patients living with dementia:
  - There were two staff who had been identified as dementia leads, although not all staff knew who these were. A cubicle in ED had been adapted to be “dementia friendly” so that patients were better able to orient themselves.
  - Training records showed that most registered and unregistered nurses had received dementia awareness training. However only 74% of medical staff had received this training.
  - There were prompts on the electronic patient record system so that staff could identify people who may have some form of cognitive impairment.
  - We were told that patients living with dementia were identified with a flower symbol on the white board in the ED but we saw that this was not used consistently. We noted also that a patient on the observation unit, who was living with dementia, had no visual symbol at their bedside on the unit’s whiteboard to indicate to visiting staff that they may need extra support.
- In the Royal College of Emergency Medicine (RCEM) audit: assessing for cognitive impairment, the trust scored in the lower quartile compared with other English trusts for the documentation of an early warning score. The trust scored 60% against a standard of 100%. An action plan was not provided to show how this performance was to be improved.

## Access and flow

- Patients did not always receive care and treatment in a timely way. Patients frequently spent too long in the ED. This led to overcrowding and queuing, causing patients discomfort and impacting on their privacy and dignity.
- The ED was not consistently meeting the national standard which requires that 95% of patients are discharged, admitted or transferred within four hours of arrival at A&E, although performance was improving and the target was met in June and July 2015.
- The MIUs consistently met this target, achieving 99.9% in the first quarter of 2015/16. The ED achieved 93% for the same quarter.
- While waiting no more than four hours from arrival to departure is a key measure of ED performance, there are other important indicators, such as how long patients wait for their treatment to begin. A short wait will reduce patient risk and discomfort. The national target is a median wait of below 60 minutes. The ED was not currently achieving this target, with the average wait ranging from 61 to 68 minutes between April and September 2015.
- Another important indicator for patients who require admission to a hospital ward is the time it takes for their transfer to take place from the time of decision to admit. The trust scored generally worse than the England average for the percentage of patients waiting four to twelve hours for admission from ED.
- Patients queued in ED, both on arrival by ambulance and, more often, whilst waiting to see a doctor or waiting to be admitted. Patients were forced to queue in the corridor or in a sub waiting room because there were insufficient cubicles to accommodate everybody who needed one. This compromised their comfort, privacy and dignity. During our evening visit we saw patients on trolleys in a busy corridor for over an hour. The sub waiting room was also overflowing with patients and relatives during our evening visit, with patients over spilling on to the corridor. Patients were seated, sometimes for long periods, in hard upright chairs. We saw one patient slumped in their chair, asleep, with their head leaning on a wash hand basin. We observed a patient having blood taken, a patient in obvious pain and discomfort receiving a morphine injection and a patient providing a personal medical and social history to a nurse, all in front of a waiting room full of people.
- Staff told us that patients frequently stayed in the ED overnight because there were no beds available in the hospital. On the first day of our visit there were six patients in the ED who had stayed overnight. Staff acknowledged that this was not ideal but told us they had taken steps to ensure their comfort. Patients had been provided with hospital beds, appropriate pain relief and had been offered food and drink. We spoke with one of these patients who told us they had spent 10 hours overnight in the ED. They told us they had only been checked approximately every one to one and half hours and had found it difficult to attract staff’s attention without a call bell.
- Failure to consistently achieve the target in ED was the highest risk on the risk register. There was a service

# Urgent and emergency services

improvement plan based upon recommendations by ECIST and a number of measures had been implemented, although they were at various stages of development. These included:

- The introduction of a rapid assessment and triage (RAT). This process had recently been introduced, on the recommendation of ECIST, with the aim of improving patient flow by ensuring that patients were examined promptly by a senior clinician so that decisions about diagnostic tests, and treatment plans were made more quickly. Two cubicles were allocated for this process at the busier times of day. The service improvement plan set out the goals to optimise utilisation of this process. During our visit we observed that some clinicians were more fully engaged with the process and more efficient and effective than others. There was an ethos of allowing the process to evolve organically but the effectiveness of this new process could not be properly evaluated, given the inconsistency in practice.
- The introduction of “see and treat” in minors. This was another ECIST recommendation. Ten Emergency Nurse Practitioners were employed and provided a service between 8am and 10.15pm. The service was not being provided consistently but there were plans to extend this service, subject to successful recruitment.
- Increase the number of patients using the Urgent Care Centre services at the ‘front door’.
- ECIST commented in May 2015 on the considerable variation in the response standards of specialty in-reach. They recommended that internal standards be implemented so that patients were assessed as soon as possible by specialties and admitted to the right ward as early in the day as possible. We asked the trust for data to quantify this problem. They told us there was an internal response time standard of 30 minutes but response times were not monitored.
- Although we heard that there was a good, cooperative relationship between the ED and the paediatric team, we were also told that response times from paediatrics were sometimes too long. An ED nurse told us about an occasion when two children waited one and a half to two hours for a paediatrician to assess them. An incident was not reported at this time.
- During our visit we saw that a child brought into the resuscitation bay waited nearly two hours to be reviewed by the paediatric team and then waited a further 80 minutes to be transferred to the children’s ward. Neither the ED staff nor the paediatric staff could explain why this transfer took so long.
- Patients who were referred by their GP for hospital admission (medical expected patients) were frequently admitted via the ED because there were no available beds. The correct process would be for these patients to be admitted directly to a ward but staff told us this was rare.
- The department consistently achieved the national target which requires the number of patients who leave the department before being seen (by a clinical decision-maker) should be less than 5% (recognised by the Department of Health as being an indicator that patients are dissatisfied with the length of time they have to wait).
- Ambulance handover times were improving. Between April and July 2015 96.6% of handovers occurred in less than 30 minutes. We did not see any lengthy delays during our visit, although during our evening visits two or three patients at a time queued in the corridor for a short period of time. Ambulance staff told us that sometimes longer delays occurred.
- There was a protocol in MIUs for the urgent transfer of seriously ill/injured patients to ED by ambulance. This included a list of conditions which would qualify for an immediate (999) response. Staff reported that emergency requests were usually met; however urgent assistance was variable because the MIU was considered to be a place of safety. A staff member at Trowbridge MIU told us that a patient with a head injury recently waited two hours for an ambulance transfer and eventually left the hospital before the ambulance arrived. The trust was unable to identify or verify this incident.
- In ED there was a front door assessment team employed by a neighbouring healthcare provider which had been developed to identify and assess patients over 65 years of age and facilitate or speed up their safe discharge home by providing practical assistance and packages of care at home. The service was available from 10am to

# Urgent and emergency services

8pm, seven days a week. ECIST had acknowledged the contribution of this service and had recommended that it be further developed. We were told that hours were to be extended in the near future.

- In the MIUs staffing levels in the department did not always allow for uninterrupted patient flow. There was no dedicated triage nurse which meant that when all nurses were occupied with a patient, patients presenting at the nurses' station were not always immediately seen. We witnessed on a number of occasions at Chippenham MIU, nurses interrupting a patient consultation to greet and assess patients presenting at the nurses' station. Staff at Trowbridge Hospital told us this could lead to "disjointed care". They said this was particularly a problem at night when the doors were locked and there was no receptionist employed. Staff had to leave patients in the department while they greeted patients (including those coming to see the out-of-hours doctor) at the hospital entrance.

## Learning from complaints and concerns

- There was a supply of leaflets available at the ED and MIU reception desks, publicising the Patient Advice and Liaison Service (PALS). Reception staff told us that they would contact the PALS office for advice if appropriate but would escalate immediate issues to senior staff. Not all patients we spoke with knew how to make a complaint but all told us they would feel comfortable to do so and felt they would be listened to.
- Complaints and lessons arising from them were discussed at monthly clinical governance meetings. Meetings were not well attended; however, minutes were circulated to all staff via the intranet and were also discussed at staff meetings.
- Staff we spoke with were familiar with the complaints procedure and they felt confident to deal with complaints, escalating to more senior staff if appropriate. Staff told us that waiting times and a lack of information about waiting times were the most common areas of concern. The ED had recently introduced two hourly tea rounds in response to complaints about lack of refreshments while waiting in the department.

- It was reported to the board in August 2015 that an in depth analysis of complaints had been undertaken in ED due to the high number of complaints received in April 2015.

## Are urgent and emergency services well-led?

Requires improvement

The service had engaged with external bodies to assess and evaluate its performance. Improvement plans had been developed, although staff had not been engaged with this process or changes in service provision and the plans did not form part of well-developed strategy or vision for the future. A number of initiatives had been introduced to address responsiveness and improve performance against national standards. Although commendable, these initiatives were in their infancy and their success had yet to be evaluated. The objectives of these initiatives still needed clarification and their protocols and processes needed to be fully developed so that they were understood by staff and staff were fully engaged in making them a success.

Service managers provided us with few examples of innovation. There was limited evidence to show that patients' views were being captured or acted on.

In our discussions with service managers, we judged that risks to service provision were well understood. However, the multifactorial risks to patient safety and quality and concerns on their 'worry list' were not fully captured in the service risk register and we could not be assured that risks were regularly discussed, reviewed and escalated. Risks identified as a result of serious incidents were not always dealt with in a timely way. Audits were not consistently used to drive service improvement.

Staff were committed and highly motivated. They worked well as a team and were well supported by their immediate managers, although they did not always feel engaged or empowered. Managers were visible, accessible and supportive, and morale among staff remained good despite very significant challenges in respect of increasing demand, lack of patient flow and staffing shortages.

## Vision and strategy for this service

# Urgent and emergency services

- The senior team in the emergency department (ED) had met in June 2015 to discuss their team goals, and values. Minutes of the meeting highlighted a palpable sense of passion to provide quality of care to patients and a great sense of team work, both as a department and as part of the wider hospital. Staff we spoke with however were unaware of an agreed vision or strategy for the service and had not been involved in setting priorities and goals for the future.
- A number of external reviews had taken place to examine the effectiveness of systems affecting patient flow. The Emergency Care Intensive Support Team (ECIST) visited in April 2014 and made a series of recommendations which were incorporated into a service improvement plan, which was regularly monitored by the trust board. A further ECIST visit was requested by the trust and took place in May 2015. The purpose of this visit was to provide a baseline from which the team and the trust board could assess progress against improvement plans. Improvement plans were being updated at the time of our visit.

## Governance, risk management and quality measurement

- ECIST commented following their visit in May 2015 on poor access to data, which they judged “must affect the quality of internal decision making”. They recommended that the information function was reviewed to better support effective operational decision making. We agreed with this observation. We also found it difficult to extract reliable data which could be used to assess the quality of service and the effectiveness of processes and pathways. For example, we found anecdotal evidence that some specialty doctors did not review patients in ED promptly enough, but we were not able to obtain data to confirm or quantify this problem.
- There was a programme of audit; however, insufficient attention and priority was given to using audit as a tool to identify shortfalls and to improve performance.
- There were good working relationships with third party providers and partners, including the ambulance service, the local mental health trust and the social enterprise organisation which ran the urgent care centre. However, there was a lack of clarity with regard to the ED’s interface with the urgent care centre.

- A risk register was maintained but it did not accurately or comprehensively capture all of the risks that affected performance and safety. Minutes of ED clinical governance meetings recorded no discussions relating to the management of these identified risks. There were no identified risks relating to minor injury units (MIUs).

## Leadership of service

- The local triumvirate management team in ED (lead consultant, matron and head of service) were described as visible, accessible and supportive. The MIU lead nurse was similarly described. Divisional managers were also regular visitors and staff felt they understood the pressures experienced in their department. Board members were not regular visitors to the department and most staff reported that they did not know them and did not feel supported by them.
- There had been safety visits undertaken by members of the board. The last safety visit to Trowbridge MIU took place in April 2014, ED November 2014, Chippenham MIU March 2015. Staff were not able to tell us about these visits or anything which had arisen from them. An initiative called “in your shoes” was described to us by the trust’s executive team. This was where a member of the executive team spent a day in a different role in the trust so that they could personally experience the challenges faced by staff. Few staff in urgent and emergency care were aware of this initiative.

## Culture within the service

- The overwhelming majority of staff we spoke with told us they felt respected and valued. Non-clinical support staff told us they were very much part of the team and welcomed in the departments.
- The majority of the staff we spoke with told us they enjoyed working in ED/MIU. Team work was frequently cited as one of the best things about working in this service. The ED management team was proud of the fact that they received many applications for senior medical staff vacancies, particularly from previous trainees. Students enjoyed their placements in ED and felt well supported.
- There was a strong emphasis on promoting the safety and welfare of staff. The internal staff survey which examined respect and abuse at work was a good example of this.

# Urgent and emergency services







- Staff told us that they received emotional support to deal with pressures and events inside and outside of work. There was a system of de-briefing which took place following difficult and traumatic situations.
- Staff were appreciated and awarded for their efforts and achievements. The ED was awarded the STAR (Service Teamwork, Ambition and Respect) Trust Team of the Year Award in 2014. This was in recognition of the staff continuing to provide high quality care for patients while major refurbishment work was underway and coping with a busy winter. Several individual members of the team were nominated for STAR awards and two nurses were nominated for the People's Choice award.
- The MIUs were nominated three times for STAR awards by the lead nurse, the divisional director of nursing and by the divisional director. They were described as "fantastic minor injury units... quietly providing a superb service... consistently providing high quality care... Working so well as a team, not only supporting each other but coveting shifts to make sure their service can be provided through some challenging staffing gaps."
- We saw no other examples of how the service gathered people's views or engaged and involved them in shaping the service.
- Staff did not feel actively engaged in shaping the service. For example staff were not consulted about the reconfiguration of the ED. However staff told us that they were encouraged to raise concerns and they felt they would be listened to if they did so.
- There were regular staff meetings held in each department. It was noted at the ED sisters' meeting in July 2015 that band 5 nurses had been asked for their suggestions as to how to improve attendance at their staff meetings. Attendance at meetings was being monitored and that staff were encouraged to attend in their own time.

## Innovation, improvement and sustainability

### Public and staff engagement

- The service used friends and family test to capture views about the service. Response rates in common with other EDs were low. It was reported to the board in August 2015 that response rates had decreased from 15.6% in May to 8.6% in June 2015. There was a slight improvement in June 2015 with a response rate of 9.6%. It was reported that hospital volunteers were to be deployed to increase and sustain response rate in poor performing areas. We heard that a volunteer had been employed one day a week in ED.
- There was limited evidence shared with us to demonstrate innovative practice. The virtual fracture clinic (referred to under 'effective') had been introduced to avoid unnecessary clinic attendances and had received positive feedback from patients. The service was striving for improvement and had commissioned external reviews of the service and was responding to recommendations. The service had achieved significant improvements in the management of sepsis. There was enthusiasm and commitment to carry out research and a number of clinical trials had been successfully recruited to. However, audit was not being used consistently to drive service improvement.

# Medical care (including older people's care)

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

## Information about the service

Medical services at Great Western Hospital include 289 medical beds, plus 10 beds on haematology/oncology. Beds are located in the medical assessment unit, acute medical care, cardiology, haematology, oncology, neurology, gastroenterology, healthcare of the elderly, respiratory medicine, and ambulatory care. The hospital serves a local population of 350,000.

We visited the following wards and areas during our inspection: Linnet (medical assessment unit) (MAU), Jupiter (older person's care, dementia friendly), Saturn (acute medical), Coate Water (day care unit), Falcon (stroke unit), Teal (general medical), Dove (cancer care) and Woodpecker (elderly care/general medicine). Most wards have four-bedded bays and side rooms. The medical assessment unit (Linnet) has 33 beds made up of four-bedded assessment bays, and a number of beds with cardiac monitoring.

The ambulatory care unit is located alongside the MAU. It has one four-bedded bay and a waiting room, a treatment room and three consulting rooms.

Falcon ward is a specialist ward providing care and treatment for stroke patients.

We also visited the cardiology suite, endoscopy suite, Kingfisher ambulatory care ward, day therapy unit (treatment with chemotherapy) and discharge lounge. We visited the bed manager's office to look at how admissions and discharges were managed. We also

visited the surgical assessment unit and other areas where medical patients were admitted to surgical wards when no suitable bed was available. These patients were known as medical outliers.

We spoke with 44 patients and four relatives. We also spoke with 116 members of staff including consultants, doctors, senior and junior nurses, managers, administrators, porters, housekeeping staff, occupational and physiotherapists and volunteers.

We reviewed 39 sets of patient records. Before and following the inspection, we reviewed information and data about medical services provided to us by the trust.

# Medical care (including older people's care)

## Summary of findings

We rated safety in the medical services, including older people's care, as requiring improvement. There were periods of understaffing or inappropriate skill mix which were not fully addressed. We saw infection control procedures and the storage of equipment and chemicals were not always safe. Staff did not always respond promptly to the care and treatment needs of a deteriorating patient, or fully consider the needs of patients with mental health issues. The completion of records did not consistently reflect the care needs of patients.

Effectiveness of medical services was rated as requiring improvement. The tools used in care plans and care rounds to measure and monitor pain relief and nutritional risks were not consistently completed and used to develop patient care plans.

The consent to care and treatment was not consistently obtained in line with legislation and guidance, including the Mental Capacity Act 2005. We evidenced patients' mental capacity had not been consistently assessed and recorded when necessary. It was not always clear how best interest decisions had been made. Staff did not monitor Deprivation of Liberty Safeguards some of which had expired without staff being aware.

We found the service provided was caring and that the staff involved and treated people with compassion, kindness, dignity and respect. However, many patients told us they did not know what the ongoing plan was for their care and treatment, and felt communication of this information was poor.

Responsiveness of medical services was good. Services were planned and delivered to be flexible and meet the needs of the local population. Facilities and premises were appropriate for the services delivered to patients. The management of access and flow through the hospital and the management of outlying patients on other wards was good. Some difficulties were encountered on discharge.

The leadership of medical services required improvement. Staff were confident at ward level about the leadership of matrons and managers. Few had understanding or awareness of the hospital

management above that level. There was some misunderstanding outside of ward areas of the level of care provided on the Coronary Care Unit and Mercury ward. This did not ensure clear leadership of the medical service.

# Medical care (including older people's care)

## Are medical care services safe?

Requires improvement



Safety in the medical services included older people's care was rated as requiring improvement.

There were periods of understaffing or inappropriate skill mix that were not fully addressed, as additional staff were not always available to increase the staff team.

We saw the majority of staff followed infection control procedures however, some staff showed a disregard or lack of understanding for infection control procedures for patients with transferable infection.

Some safety systems were not followed by staff; these included safe storage of chemicals and sharps equipment. This may place patients and visitors at risk. Some non-prescription medicines were also stored in the sluice and were seen to be used by more than one patient. This posed a risk of cross infection.

The completion of records was not consistently undertaken. Staff did not consistently assess, monitor or manage the health, care, treatment and associated risks for some patients' health, and did not ensure appropriate record keeping evidenced this.

The management of patients on medical wards with mental health issues was not fully considered. For patients with a high risk of attempting suicide, consideration of ligature risks on the ward were not recorded, environmental risk assessments not completed and appropriate staffing was not put in place.

### Incidents

- Between July 2014 and June 2015 there were 2,046 incidents reported in the medical division, the majority were considered low harm or no harm to the patient. There were 42 moderate incidents, 12 severe, and two deaths reported. The majority of incidents (1189) were reported by staff within 14 days. 10% of all incidents took over 60 days to investigate and 5.7% of incidents took over 90 days to investigate
- Staff were encouraged to report incidents and told us they felt able to do so and received feedback following

a report. Incidents were investigated by the senior staff on the ward and detailed reports were shown to us which included actions and recommendations to reduce the risk of the incident in the future.

- For October 2014 to March 2015, the trust reported 31.53 incidents per 100 bed days. When compared to all other acute (non-specialist) trusts this was the 39th lowest reporting trust out of 137 trusts. Lower rates of incident reporting is not considered good as reporting should be encouraged in order to learn from incidents that have happened
- One Never Event had been reported in August 2015. This was related to a procedure being performed on the wrong patient within endoscopy. A never event is a serious, largely preventable patient safety incident that should not occur if the available preventative measures had been implemented. Staff from the department involved confirmed that the investigation was on-going with actions to be agreed once completed. This investigation was within time scale and followed the standard process We asked staff and found areas of the hospital had not yet been informed of the never event having taken place This did not ensure learning from the incident to reduce the risk of reoccurrence in other areas of the hospital.
- Each ward sister and manager had information regarding incidents reported in their department but some ward staff told us did not get learning from incidents from their own or other areas in the trust. This would indicate that information was not consistently passed on to staff.
- The most frequently reported incident was patient accidents (745, which was 36%). Nine patient accidents that resulted in severe harm. All were attributed to slips/trips/falls but not all incidents defined what severe harm had resulted. Ward staff confirmed that accidents were investigated and learning used to change practice when possible.
- There were 18 serious incidents reported from May 2014 to April 2015 in the medicine division. Seven of the serious incidents were grade three pressure ulcers, six out of those seven were acquired grade three pressure ulcers from a geriatric medicine ward. Five serious incidents related to falls and two were about ward closures.

# Medical care (including older people's care)

- Duty of Candour legislation has been in place since November 2014 and requires an organisation to disclose and investigate mistakes and offer an apology if the mistake results in a death, severe or moderate level of harm. We saw evidence that showed patients had been provided with written information in accordance with the Duty of Candour legislation. Staff training records did not include training for the duty of candour. Staff we spoke with on the medical ward were aware of the hospital policy and their requirements of the duty of candour. We saw serious incident investigation reports and an initial report following a never event which detailed how the family of the patients received a verbal apology and information relating to the incident. We saw written responses to patients and their families that acknowledged where the service provided had caused concern to them and included an apology from the trust.
- The trust audited all deaths detailing the number of deaths under medical specialties over the last 12 months. The Trust Mortality Group meeting minutes for September 2015 showed that review of respiratory cases had taken place and an action plan put in place. This action plan was to be followed up. Mortality dashboards were being rolled out across all specialities.

## Safety thermometer

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. The trust had a performance dashboard in place for all areas within the medicine division. These included the number of falls, pressure damage, infection control, venous thromboembolism (VTE) and incidents.
- The medical wards displayed information relating to the safety thermometer and incidents that had occurred. For example, we saw data that showed the number of falls and incidents of pressure ulcers on the wards. All pressure wounds were checked within two hours of admission to ensure they were recorded correctly as hospital acquired or already in place on admission.
- On Jupiter ward, there had been a significant increase in falls in August 2015 from the previous three months,

with 15 falls taking place. As a result, staff had been reminded to ensure the half-hourly evening checks were undertaken. Discussion regarding falls was carried out in staff meetings together with instruction for staff to work within bays when carrying out paperwork. Desks had been installed within bays to enable staff to observe patients whilst carrying out paperwork; however, we did not see these being used by nursing staff. We observed staff continuing to use desks on the ward corridors, out of the bays, to update their paperwork and the desks in bays provided were not used for their intended purpose.

- The electronic medication system allowed an audit of preventative treatments for VTE to be carried out, which included both prescribed and given preventative treatments. Staff received feedback on any issues. Junior doctors prescribed both preventative medication and anti-embolism stockings (stockings used to reduce the risk of the patient developing a deep vein thrombosis. Scores were reviewed monthly by senior staff. As a result, staff had been identified that it was possible to tick a 'completed' box on the electronic prescribing system (EPMA) to access the prescribing screen without actually completing a risk assessment on the individual patient. Incident reports were seen where appropriate medication or stockings had not been prescribed. The EPMA working group were looking at a failsafe solution to this, though it had yet to be put in place.

## Cleanliness, infection control and hygiene

- Wards and departments we visited were clean and tidy. Some curtains on wards had not been changed since April 2015. Ward staff said there was, to their knowledge, no set timescale for them to be changed, but could be changed if noted to be unclean. Staff did not know who monitored the changing of these curtains and how often it happened. The Patient Led Assessments of the Care Environment (PLACE) 2015 scored the trust at 97.9% for cleanliness.
- Audit records evidenced that matrons undertook regular checks of the wards, which included general standards of hygiene but did not include staff infection control practice. Between July 2014 and June 2015, staff within the medicine division reported 36 infection control incidents, 11 of which were of moderate risk.

# Medical care (including older people's care)

- Staff were required to complete infection prevention and control training. Data provided showed 70% of staff working with acute medicine, diabetic and endocrinology services had completed this training. This did not meet the trust training target of 80%. Staff told us a recently planned change in hours would enable them to have time to undertake training on the ward each week. This would be scheduled in to their weekly rota.
- Hand sanitising gel was located at the entrance to each ward. Throughout the wards and departments there was adequate hand washing facilities. We observed staff used the hand gel during their duties and washed their hands in the correct manner in line with infection, prevention and control guidelines.
- The acute stroke ward (Falcon) and the Coronary Care Unit staff were positive about the cleaning services provided by an external provider who were contracted to deliver this service throughout the hospital. They had the same cleaners allocated to their ward who were helpful and supportive to staff and patients.
- The wards used green labels to identify when cleaning of the equipment and environment had occurred and who had carried this process out.
- Chemicals and substances that are hazardous to health (COSHH) were observed in areas that were not locked and therefore accessible to patients and visitors to the wards. Cleaning materials, including chlorine tablets, were in the sluices, which were unlocked. We raised this as a safety issue with ward staff at the time. We revisited two of the wards during our inspection and saw that one of them still had chemicals unlocked in the sluice.
- Sharps bins were in place throughout the medical wards and departments for the safe disposal of used needles and other sharp equipment. However, we observed these were not consistently closed when not in use and some were over two thirds full and still being used. This meant staff were at risk of a needle stick injury.
- Each ward had a performance board at the entrance to the ward that showed if they had had any incidents of infection. No cases had been reported in the August 2015 Medical dashboard update. Wards audited the cleanliness of the clinical areas each month. For example, Neptune ward displayed information that showed they had reached 94% on their most recent audit.
- The hospital carried out audits of hand hygiene on each ward and unit. The information from individual wards and departments was displayed for patients and visitors to see. Hand hygiene audits for Falcon ward scored 95% for the months July to September 2015 and 97% for patient equipment.
- We observed a staff member on Falcon ward who entered a side room that was being used to isolate a patient with a transferable infection. They wore a plastic apron on entering the room; they left the room without removing their apron and washing their hands. We observed them then enter another four patient bay and handle breakfast items and then enter the ward kitchen and pick up cutlery, all the while still wearing the same plastic apron and not having washed their hands. This put patients at risk of infection. We established the staff member had received infection control training.
- We also observed a visiting social worker who entered a room with a patient being isolated because they had a transferable infection. The social worker did not wear a protective apron. They sat on the patient's bed and washed their hands on the way out. They were not directed by staff to the protective equipment available.
- Staff training for infection control was provided by the hospital Training Academy. The staff training records (July 2015) showed that out of the 25 medical areas listed only seven areas achieved the 80% and above target for staff training for infection prevention and control including hand hygiene.

## Environment and equipment

- The Patient Led Assessments of the Care Environment (PLACE) 2015 scored the trust at 93.5% for condition, appearance and maintenance.
- Each ward had access to equipment for use during the provision of clinical care and treatment. Much of this equipment was single use. We observed the store cupboards were unlocked and, in some cases, the doors remained wide open. We observed on Neptune

# Medical care (including older people's care)

ward there were stitch cutters and scissors stored in this area. This meant all patients including those living with dementia and mental health issues and visitors to the ward had access to potentially risky equipment.

- Medical equipment on wards and department was serviced and maintained on an annual basis. Stickers were fixed to the equipment, which showed they had been serviced and maintained within the last year.
- There were plans to improve the layout and environment of the endoscopy department to enable the Joint Advisory Group (JAG) accreditation to be reconsidered, previous accreditation had been withdrawn. JAG accreditation demonstrates a hospital has the competence to deliver against national endoscopy standards and measures.
- Patients admitted to the medical wards had access to showers that were located within the bays or side rooms. The showers were of different styles, with some being a wet room type with level access and others having a small step to access the cubicle. These had a low screen, which could be closed to reduce splashing. The rooms were small. There had been one incident recorded following a patient fall as a result of catching their mobility aid on the shower lip. Not all patients would be able to access the shower if they required level access. One patient told us that the showers were not usable as they flooded and staff had to put towels down to absorb the water.
- On Jupiter (the dementia-friendly ward), we asked what made the unit dementia friendly. The refurbishment, which had taken place the previous year, included softer floors in case of falls, signage to aid direction for patients, dementia informative clocks, use of colours to define areas and a seating area mid ward with reading material to support patients to take a break during walking. Each bay was a separate colour and had a small nurse's station to ensure staff were able to observe patients. However, we did not see staff using these stations. One side room had the toilet and shower door painted the same colour as the walls and so was not visibly different. When patient's curtains were closed around their bed in one bay, together with the positioning of the nurses station and visitor's chairs access to the toilet/shower for patients with visual difficulties or mobility aids would be difficult.

- Each ward and department had at least one resuscitation trolley, which contained emergency equipment and medication for use in the event of a patient suffering a cardiac arrest. These trolleys were secure to prevent equipment or medication going missing and were checked each day to ensure they were ready to use in an emergency.
- We visited the hospital at night and saw that whilst wards were secured, larger areas of the hospital were accessible all night. Two members of security staff were on duty at night and at intervals patrolled the hospital. However, whilst present for four hours in the evening we did not see any form of security.

## Medicines

- The trust provided guidance and information to staff in a medicines management policy, which included the ability for local procedures to be set up for self-administration within defined clinical areas and for general or specific medication.
- Incidents regarding medication were reported via the trust's electronic reporting system. Between July 2014 and June 2015 staff reported 270 medicine incidents, two were of moderate harm, 20 were low harm and 248 were recorded as no harm. The electronic prescribing system monitored missed doses and provided a report to each ward. In August 2015, Jupiter ward had 30 missed doses of medication with only 11 having a note attached to the record with an explanation. Staff were reminded at a staff meeting to ensure an explanation was provided as to why medicines had not been administered.
- NICE guidelines recommend all patients should receive a medicine reconciliation within 24 hours of change of care setting. The trust statistics for medicine reconciliation for September 2015 showed 45% complete within 24 hours. This did not meet the trusts own standard of 80% Medicine reconciliation did not take place out of hours and were not formally completed by anyone except the pharmacy team. The trusts own key performance indicators were not met for April, May or June 2015 (48%, 45%, and 45% respectively).
- We saw each ward checked and recorded their own fridge temperatures to ensure medicines were stored at the correct temperature. We saw Neptune ward had

# Medical care (including older people's care)

a higher than recommended fridge temperature. This was discussed with senior staff on the ward. The controlled drugs were checked on a daily basis on the wards and departments we visited.

- Patients described incidents when they had not received their medicines in a timely way. On Neptune ward one patient missed having their antibiotics due to bloods not being taken during the day. A patient on Jupiter ward told us their medication from home had been lost on admission and so had not been given.
- The trust had an electronic medication dispensing system; however, this was not fully implemented in all areas. The coronary care ward could use the electronic ordering system for medicines but not for intravenous fluids. As a result, staff had to run two systems alongside each other. Electronic prescribing was a challenge for junior doctors who told us they did not receive training and support when starting on a ward and had to 'learn on the job'. The trust told us that Electronic prescribing training was included as part of the junior doctors Trust induction programme.
- Patient allergies could be recorded in three places; on the electronic medication system (EPMA), the medical paper notes and the nursing system. This created a risk to patients if staff failed to document on one of those systems. We saw a patient with a wristband to alert staff to an allergy but the patient was not clear if this included any medicine allergies. In the medicines administration chart for one patient, three out of four supplementary prescription sheets seen did not have allergies recorded. Medicines had been prescribed and administered. One supplementary medicine chart noted allergies 'unknown', but this contradicted the EPMA record, which recorded allergies to two medicines.
- We saw opened and unnamed topical medication stored in sluices and on trolleys used for intentional rounding, which is where nursing staff undertake regular checks with individual patients at set intervals
- The creams were not consistently dated upon opening so staff were not aware of the expiry date. This may have been a risk to patients if used after the recommended time.
- Two members of staff told us they used the cream for more than one person. This did not promote the

control and prevention of infection. Staff explained that the risk of cross infection when using one pot of cream for multiple patients was mitigated by decanting the cream required into a smaller pot and putting the patients name on it. This put patients at risk if creams were incorrectly labelled or used after the recommended time.

- Medicine trolleys on Kingfisher ward were stored in an unlocked clean utility room. One trolley had been left unlocked which meant medicines were accessible to patients and visitors. We informed staff who locked this immediately.
- Pharmacy services were available at weekends within working hours and on call out of hours. There was a discharge team (two pharmacists and one technician), but the pharmacy was not meeting the target of 80% for the take-home medicine turnaround time of two hours. We saw one take home medicine that was notified to the dispensary at 09.30; the discharge team finished the clinical screen at 11.30 it then needed to be transported to the dispensary to be dispensed. Between 1 April 2015 and 30 June 2015, only 67% of take home medicines were processed in two hours or less. Some wards, including the Medical Assessment Unit, had stocks of some medicines so they could dispense to patients being discharged and reduce waiting times. We saw safe systems in use. These needed two trained nurses to sign to ensure they had dispensed medicines correctly.
- A patient on Neptune Ward commented that their discharge had been delayed by three hours waiting for their tablets to be brought dispensed from pharmacy. We received further information that described a delay in discharge due to the extended timescale of take home medicines arriving on the ward. We saw two patients in the discharge lounge who were frustrated by waiting for medicines. One left immediately on receiving the take home medicines and did not want to be counselled about their medicines.
- Pharmacy staff attended site management meetings to provide update information on any possible delays to providing medication for patients to take home in order to advise the trust bed management team of any potential delays in discharges.

## Records

# Medical care (including older people's care)

- Records training was provided to all staff however, updates were not well attended. Out of 25 areas recorded, only four medical division areas were compliant with their mandatory training.
- Nursing notes held a signature list of every member of staff who had written in their notes together with a printed name so that it was clear who the member of staff who had provided care and treatment was
- Care plans were observed to be used on the medical wards. These were in the form of generic care plan booklets that were commenced on admission and updated when care needs changed.
- The care plans were generic pre-printed task-focused lists that staff ticked and dated when they had provided care to patients. These did not provide detail on the individualised care needs and requirements of patients. For example, the records for personal care did not detail the patient's preference or how much help they needed.
- The care booklets were relatively new to the trust and staff told us they were time consuming to complete. The Medical Assessment Unit had not completed them due to the time it took and had produced their own shortened version. However, this also lacked detail to ensure patients' specific needs could be met.
- Risk assessments were included within the care plan booklet but were basic and required staff to tick boxes; they did not include space for personal detail. A variety of risk assessment tools were in place to identify risks of thrombosis, pressure damage, moving and handling, nutritional risks and falls. We saw that in records Malnutrition Universal Screening Tools (MUST) were used. These nutritional screening tools were not consistently completed. Falls risk assessment identified concerns but had no associated care plan. Within one set of records, risk assessments for bed rails identified they should not be used. A decision to use bed rails had been made but there was no clear rationale as to how this decision was reached. One patient had reduced mobility; however, no full risk assessment had been completed. There was no additional information on the action staff were to take to reduce the risk for the patient during the provision of care and treatment. We saw that when a fluid and food record was indicated these were not consistently completed and reviewed to establish any risks.
- Intentional rounding forms were in place and up to date to identify the contact with patients by nursing staff and the regular care provided.
- We looked at four sets of nursing notes on Mercury ward and noted risk assessments and care plans were not fully completed. They lacked sufficient detail in all areas to enable individual care to be provided. For example, there were gaps in the recording of personal care so it was not possible to identify the patient's choice, what support they needed or had been given. Risk assessments and care plans for skin pressure relief did not identify what help was needed or how the patient could be supported to remain as independent as possible.
- We looked at four sets of patient notes on Kingfisher ward. Two had incomplete admission documentation, with no details on relevant medical history, current medication and person to contact on discharge. We saw two patients with sepsis pathways not completed. We saw care plans were initiated but not completed.
- We looked at two sets of records on the Medical Assessment unit (Linnet ward). These did not have completed risk assessments in place. One patient had a MUST form not completed to identify any nutritional risk but was receiving intravenous fluids to maintain hydration.
- On Neptune ward, dementia and delirium assessments were not completed; capacity and best interest assessments were not fully completed.
- On Falcon ward, dieticians wrote patients up for tube feeding regimes. However, there was evidence that these regimes are not consistently signed by the dietician. The remaining records seen on Falcon ward were fully completed.
- Medical records did not consistently provide information regarding the ward on which the patient was treated or seen by the doctors. Not all doctors printed as well as signed their name and signatures were in some cases illegible.

# Medical care (including older people's care)

- Lockable trolleys for storing patients' records were available on all wards and departments. When the trolleys were unattended, we saw patients' confidential and personal information was stored securely. We saw that white boards containing personal patient information had been moved to offices out of public sight or had patients names obscured.

## Safeguarding

- Safeguarding training was provided to all staff and was required to be updated annually. This was delivered by an electronic learning package. Mandatory training for Safeguarding Vulnerable Adults including learning disability awareness had full compliance with the exception of respiratory medical staff and respiratory nurses. Training for equality and diversity awareness was also not completed fully in 15 out of the 25 medical areas. This equated to 73.8% of staff completing the training overall within medical care. This did not meet the trust target of 80%. There was a plan to increase the level of safeguarding training for staff, dependant on staff group and level of responsibility.
- Information was displayed on noticeboards in all medical areas regarding the trust's safeguarding policies and procedures. The information included a flow chart for staff to follow when a possible safeguarding concern had been identified, together with contact details for the person to contact to escalate the issue.
- All staff we spoke with were aware of the hospitals safeguarding procedures. Staff were confident about what constituted a safeguarding incident and the action they would take to keep patients safe.
- One matron, new to the post, had corporate responsibility for safeguarding, dementia, learning disability and mental health. The trust safeguarding team consisted of band 7 nurses with a mental health background, a children's safeguarding lead and a liaison link nurse for community services. A further administration staff member was available for support.
- Staff shared their experiences of reporting safeguarding concerns and how learning from the process had been used to implement changes to improve the process. A safeguarding web page had been developed on the hospital intranet for staff. Here staff were able to access, referral forms and view a decision-making flow chart.

The safeguarding lead nurse told us there had been an increase in reported safeguarding concerns as there was increased staff awareness. Learning from safeguarding concerns had been fed back into ward meetings and safeguarding was a standard item on the trusts divisional governance meetings.

## Mandatory training

- Mandatory training was available to staff in an online electronic format and for some subjects face to face. The hospital training department sent emails to the staff member, ward sister and manager when training was due. The ward sisters were able to access staff training records. Some wards kept a copy of the training record for each staff member in their personnel file which was stored securely on the ward.
- The trust had a mandatory training compliance target of 80%. Across the medical division, records showed that target was not consistently met for some training subjects. For example, compliance with training for fire safety awareness was 66.9% consent, mental capacity and Deprivation of Liberty training 73.9%, these areas did not consistently meet the trust target of 80% across ward areas. Training for slips, trips and falls was not fully completed across all wards and departments 77.8% completed.
- Adult basic life support (ABLS) training was included on the list of the trusts mandatory training. Out of the 25 medical areas identified, only seven areas had achieved 80% training compliance. The trust total compliance for ABLS was 71.8% for medicine areas.

## Assessing and responding to patient risk

- Each shift was allocated time for information about patients to be handed over between staff. We saw several 'white board meetings' and observed a good handover of patient information. We also observed multi-disciplinary meetings attended by all health professional groups included in patient care. These meetings were well managed and productive.
- Weekend plans were recorded by doctors in patients' medical notes; this was to ensure that when the doctors providing care were not available, a plan was in place for the patient. We saw that particularly for the outlying patients a clear plan was evident.

# Medical care (including older people's care)

- At busy times, medical patients were admitted to surgical wards if there were no dedicated medical beds available. These patients were known as medical outliers. During bed management meetings staff collectively discussed risks for individual patients. These discussions included when considering the allocation of a bed for medical outliers and when moving patients internally to ensure they were in the correct place to meet any identified risks. There were no written risk assessments or records that reflected these conversations and therefore did not evidence the process that was followed regarding bed allocation.
- Staff we spoke with on the wards used for medical outliers were clear of the criteria identified to promote patient safety when placing medical outliers on the ward. However, staff told us of occasions when the criteria had not always been met and how this had been detrimental to patients on the ward. For example, on a surgical ward a patient with dementia had attempted to get into bed with a post-surgical patient causing them discomfort and fear. At the time of our inspection, staff on two surgical wards confirmed to us they were able to care for the medical patients who had been admitted to their ward safely and effectively.
- The hospital used the National Early Warning Score system to identify from a series of observations when a patient was deteriorating. The scores gave criteria for action and instructions for staff to follow. However, two patient records showed National Early Warning Scores were not always actioned. For example, one patient had their observations recorded twice daily but the level of scoring meant observations should be repeated within four to six. No recorded explanation was available as to why the appropriate indicated action had not been taken. A further patient showed a variety of scores over three days, which showed they should have had increased observations. No increase in observations was seen to have been taken, nor a recorded explanation why action had not been taken.
- The trust undertakes quarterly audits of NEWS scores and we looked at results for July 2015. Overall compliance for the organisation with this audit was 82%, which was a decrease from quarter four results of 90%. Acute services achieved 78% compliance overall against the set criteria. Areas for improvement had been identified to include the trust moving over to a new observation chart. Identified ward champions and ward managers would continue to raise the awareness of the significance of observations and accurate chart completion
- The management of patients on medical wards with mental health issues was not fully considered. For patients with a high risk of attempting suicide, consideration of ligature risks on the ward were not recorded. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of strangulation. Ligature points included shower rails, pipes and radiators, window and door frames. The trust had clinical guidelines available for patients who required close support and a risk assessment and care plan available. Close support was listed and included harm to self. The trust explained that "If a patient is classed a high risk patient and identifies that they will require RMN [Registered Mental Health Nurse] or close support this is organised soonest to ensure close monitoring and is highlighted to the emergency department (ED) coordinator and site management team". We saw that an assessment of a patient had taken place in the ED to identify suicide risks but when transferred, no ward-based assessment had been completed and no close observation was in place to reduce this risk. The trust has told us that they were not aware of a risk matrix used for patients with suicidal thoughts on general medical wards. Staff did not have a ward management plan and no staff training in place for ligature risks. The trust told us this was currently being reviewed.
- Patients admitted to the Coronary Care unit had a varying level of dependency. Some level 2 critical care was provided. We requested from the trust the number of patients having been treated as level 2 critical care on the CCU. We were not provided with the number. However, we were advised by the trust that those patients with higher needs had the consultant and skilled nurse support they needed for the procedures undertaken.

## Nursing staffing

# Medical care (including older people's care)

- Staff consistently told us that wards and departments were short of staff, which raised concerns for them regarding the delivery of patient care.
- The trust used the Shelford Safer Staffing Tool 2014. The Safer Nursing Care Tool has been developed to help NHS hospital staff measure patient acuity and / or dependency to inform evidence-based decision making on staffing and workforce. The tool looks at dependency of patients and data collected and used a multiplier tool to calculate how many nurses should be on each ward. Acuity and dependency measurement currently took place at least twice yearly (January and June).
- The trust risk register stated that there were 90 nursing vacancies across the unscheduled Care Division (medical care). This area of identified risk was due for review 30 October 2015.
- In order to increase staffing in areas of need, nursing staff were moved from ward to ward. This meant staff numbers and skills were depleted on the staff's usual ward. The trust attempted to backfill into those wards with agency staff, but this was not always possible. Those wards were then left short of staff. For example, during the inspection, the Medical Assessment Unit (Linnet) was short of staff. Staff were moved from the medical wards (one trained nurse from Mercury ward) to Linnet and Mercury ward worked with four trained nurses instead of their allocation of five.
- We visited Mercury ward to see how this affected the workload. Staff explained it meant one trained nurse had to work as a co-ordinator while also looking after nine patients. Staff explained that patient dependency was considered and sometimes if the dependency changed, the ward manager would work on the ward to make up the correct staffing numbers. However, the ward managers did not work in the evening and so staffing risks would need to be re considered again in the evening to ensure sufficient staff were on duty. In some cases, staff had been moved from wards to the unit for a three-month period with agency staff used when possible to back fill the vacancies.
- Boards were on display on each ward that held information on the staffing establishment. The board indicated if they were short of one trained nurse but had increased staffing by one nursing auxiliary during the early and late shift. However, when we spoke with staff this information was incorrect and had not been updated for two days.
- We looked at staff rotas that showed when the unscheduled care department, which includes medicine and the emergency department, had not had a full staff complement. From the 6 September to 3 October 2015, we saw that every day for the whole period gaps in shifts were not filled. Most vacancies were for healthcare assistants and band 5 and 6 nurses. For example on the 31 August 2015 10 shifts for a variety of staff including senior trained nurses and healthcare assistants were not covered on 1 October five shifts were not covered.
- Jupiter ward was described as a dementia friendly ward. Staff told us that within the agreed staff compliment there were not enough staff on duty to ensure each bay was sufficiently observed. There were five trained nurses and four healthcare assistants on duty each day. On the days of our inspection an extra health care assistant was on duty specifically to observe three patients with an identified high falls risk. Staff explained that when the trained nurse was busy doing medicines and the healthcare assistant was busy serving meals, there were delays in providing any requests for care in each bay.
- Teal ward had ten whole time equivalent posts vacant and, as a result, there was a high usage of bank and agency staff. Staff told us that staff shortages meant training had been cancelled and they considered call bells were delayed in being answered.
- Kingfisher ward had five whole time equivalent staff vacancies and the ward was seen to be working short of staff. On the first day of our inspection, we saw that for both the late and night shifts they worked with two trained nurses and one health care assistant instead of the planned two trained nurses and two health care assistants. We visited this ward at night and the two of the night staff were agency staff as there were insufficient ward staff available.
- Woodpecker ward had five vacant whole time equivalent vacancies being filled temporarily with bank or agency staff.

# Medical care (including older people's care)

- The Coronary Care Unit (CCU) staff told us that, on some occasions, staffing did not meet the national standard level. The staff raised incident reports when they had to work short of staff because CCU staff had been taken elsewhere in the hospital to cover staff shortfalls. One staff had been moved for three months and one for five weeks.
- The Medical Assessment Unit (Linnet) had employed ten new and inexperienced staff. In an attempt to stabilise and support this new team, six whole time equivalent ward staff were moved to the MAU from other wards for a period of three to six months. There were currently 12.25 WTE nursing vacancy on the Medical Assessment Unit
- The Day Therapy unit provided day treatment for patients receiving chemotherapy. Staffing levels varied and the level of staff with chemotherapy training was important for the smooth functioning of the unit. Staffing requirements were for six chemotherapy trained nurses on duty each day. On the day of our inspection there were six trained nurses, however two were sent to Coate Water ward and one remaining nurse was not trained in chemotherapy treatment. This left three nurses who were able to undertake the treatments that day. Staff told us this was an existing problem; it was on the risk register and whilst divisional staff were supportive, they felt under pressure.
- Saturn ward had historically experienced staffing issues. Staff told us this was currently stable, senior nursing staff did not have any set clinical shifts but worked on the ward when the dependency of patients needed this.
- Falcon ward had 10 to 12 new staff appointed in the last year, mainly from overseas, although not all had remained at the trust. This put pressures on experienced staff inducting and training new staff who then left so the process was required to start again. There had been four new nurses taken on in the last two months. Staff vacancies included two band two nurses and 24 hours each week for a band six trained nurse. Staff were able to work overtime but we were told did not always want to, as they came into support their colleagues, wards and patients and then were moved to another ward. Concerns were raised by staff that the stroke unit very rarely got help from elsewhere in the hospital if short staffed as the management perception was they were not too busy as they only had 18 beds despite high acuity.
- On Beech Ward, a surgical ward, staff told us that due to the high numbers of medical outliers placed on this gynaecology and breast surgery ward last winter the skill mix had been reviewed in line with the acuity of patients. Staff were clear their ward sister, manager and divisional nurse lead were supportive in providing additional staff if the acuity from outliers required this.
- Neptune ward had one full time equivalent nursing staff member over establishment. This was due to changing staff hours to long days, which meant some part-time staff increased their hours. However, we saw that on our unannounced visit Neptune ward were working short of one health care assistant, we were not made aware of the reason for this.
- Agency staff were provided with an induction to the ward at the start of their shift. Where possible agency and bank staff were booked to work on wards they had previously worked on to aid continuity to the ward staff and patients. Trained nurses gave us examples of agency staff who had worked on their wards many times.
- Patients consistently told us during our inspection there were sufficient staff on the wards to meet their care and treatment needs. However, on Mercury ward one nurse stated they were not able to provide showers to all of the patients due to the time constraints and lack of staffing.
- Sickness rates between January 2014 and May 2015 showed that some areas exceeded the trust target of 3.5%. These areas included the acute medical unit, the acute cardiac unit, the cardiac catheterization unit and Jupiter, mercury, Saturn and Woodpecker wards.
- Between July 2014 and June 2015, staff reported 166 incidents related to staffing, facilities and the environment, five of which were low harm and 161 were no harm.
- Therapist access on the stroke ward was Monday to Friday only by an occupational therapist and physiotherapist. The therapists were employed by an external organisation and worked within a contract

# Medical care (including older people's care)

agreed between the trust and their employer. The service level agreements in place did not cover for sickness and annual leave so staff confirmed that Falcon ward patients who were reliant on that therapy were left without. Therapy support, apart from acute respiratory treatments was not available to patients on the stroke ward at weekends. Jupiter ward (Dementia Friendly) had access to therapists Monday to Friday with on call therapists available out of hours and at weekends.

## Medical staffing

- Staff confirmed they had access to an on call consultant and that they were able to contact a consultant at all times for support, guidance and information. The hospital had similar levels of junior and consultant grade doctors compared to the England average. Medical staff vacancies were highest in the Medical Assessment Unit (Linnet), ambulatory care and short stay unit, and among general medicine junior doctors.
- When planning to attract junior doctors to the hospital an academic package had been provided. This had encouraged an increase in junior doctors to the hospital and had a positive impact on medical staffing.
- Consultant cover was available on the stroke ward (Falcon) from Monday to Friday, with on-call access out of hours and at weekends. Consultant access on weekends could also be obtained through the Trans Ischaemic Attack (TIA) clinic Saturday and Sunday mornings for urgent risks identified. Other patients were seen by the on call medical team.
- There was a gastro intestinal (GI) bleed rota in place for access to medical staff in case for when emergency care needed both during the day and out of hours. There was a GI consultant 'on-call' for GI emergencies.
- There were three general medical consultants available. Two did a morning ward round on LAMU, one did a further afternoon ward round on LAMU and was then on call overnight. The third did a round of general medical wards seeing potential discharges, new and sick patients as required.
- The coronary care unit had their own junior doctor on the ward with two registrars and consultant access. At

weekends there was one cardiology consultant on site who did a morning ward round on CCU followed by in-reach to Mercury and LAMU seeing potential discharges, new and sick patients as required. After 5pm, the consultant and junior doctor cover are no longer available and the medic on call for the hospital covered the unit. There was a risk that the hospital medic may not have had cardiology experience; however, the registrar and consultant were on call to provide advice and support.

- The trust had experienced pressure on accessing medical beds. As a result, a number of patients received their medical care and treatment on wards that were not within the medical division. A locum consultant had been appointed for a fixed period to manage the outlier patient's care and treatment. Staff were positive about this role and provided examples of how this had improved the patients care and treatment and supported the ward staff. The locum consultant was due to end their contract three weeks after the inspection and staff were concerned that there was no plan in place for when they left.
- We saw ward handovers and multi-disciplinary meetings taking place and saw that ward rounds followed. We attended an evening medical handover; attended by doctors but no nursing or outreach staff. There was no record of attendees, guidance on who was to be discussed or written details when handed over, however we saw that the verbal clinical handover of information was thorough.

## Major incident awareness and training

- The trust had in place a major incident plan that covered the actions to take should there be an escalation in demand, a specific incident that would disturb normal service delivery and any significant or major incident. The plans included actions to take both in hours and out of hours.
- Staff told us that they were aware of a major incident plan and would follow instructions from senior staff. We saw on Falcon ward good emergency procedures displayed and clear signage for evacuation.
- Winter pressure arrangements were in place in the form of an escalation process with a procedure in place and managed by the bed management team.

# Medical care (including older people's care)

## Are medical care services effective?

Requires improvement



We judged effectiveness within medical services as requiring improvement. The care plans used to measure and monitor pain relief were minimal and did not include ways to support patients with communication difficulties. The tools used to identify nutritional risks were not consistently completed. Staff supervision was not well recorded.

The consent to care and treatment was not consistently obtained in line with legislation and guidance, including the Mental Capacity Act 2005. Where appropriate, patients' mental capacity had not been assessed and recorded. It was not clear how best interest decisions had been made. Deprivation of Liberty Safeguards were not monitored. Two out of four reviewed had expired without staff being aware. This may have affected how staff managed the liberty of those patients.

The trust took part in national audits and used the outcomes from audits to improve services. A trial of seven-day therapy access that provided good outcomes and had arisen following the Sentinel Stroke National Audit Programme (SNNAP) resulted in learning but was subsequently stopped due to lack of funding.

Staff worked well as part of multidisciplinary teams to ensure a quality service to patients.

### Evidence-based care and treatment

- The hospital provided staff with information and guidance through policies and procedures accessible through the intranet, and through learning on the wards. The policies and procedures used within medical care were reviewed regularly and were in line with national guidance provided by the National Institute of Clinical Excellence (NICE). The guidance used was routinely reviewed for compliance by the hospital.
- The hospital contributed to national audits including the Myocardial Ischemia National Audit Programme, the National Diabetes Inpatient Audit, the National Cancer Patient Experience Survey and the Sentinel Stroke National Audit Programme.

### Pain relief

- We saw staff ask patients if they needed pain relief during the provision of care and treatment and during the medication round. However, we did not consistently see noted in records that staff asked patients about the effectiveness of the medication following administration.
- Tools used to measure and monitor pain management were not effective. Records for the medical assessment unit (Linnet) showed a minimal assessment, consisting of the site and type of pain. The assessment did not include any observation of body language or facial expression for those patients who were not able to speak or make their pain known.
- The care plan and care rounds document used on the wards showed a basic pain assessment that did not include a scale of pain to measure if pain relief was successful. The tool did not provide staff with any alternative means to measure pain, such as a range of facial expressions to ascertain the patient's level of pain should they not be able to communicate.

### Facilities

- The medical assessment unit (Linnet) was providing mixed-sex accommodation. This meant male and female patients were in the same four-bedded bay. At this time, curtains were closed around them. We were told this was due to capacity pressures and the need for close observation. This was described as a short-term measure until the patients were transferred to the ward or reconfiguration of the ward was possible to enable same-sex bays.
- The Department of Health document 'Eliminating mixed-sex accommodation' says one unacceptable justification for breaching its guidance is a shortage of beds. The hospital had a same-sex accommodation policy that stated that it planned to care for patients in a single-gender environment, including accommodation and facilities. This was unless there were exceptional circumstances based on clinical need, or very specific care needs, while respecting patient privacy and dignity at all times. The trust told us, "There have been no MSA (mixed-sex accommodation) breaches" and "There has been no specific divisional priority or national clinical audit relating to mixed-sex breaches - medical wards".

# Medical care (including older people's care)

## Nutrition and hydration

- The trust used the nationally recognised assessment tool, Malnutrition Universal Screening Tool (MUST) to identify risks and the actions staff were to take to reduce the risk to patients to ensure they received adequate nutrition and hydration. However, these assessments were not consistently completed. We looked at 12 sets of notes on Woodpecker ward that did not include complete food and fluid records to identify any shortfalls in the patients' intake or actions needed. Staff had access to dietitians mid-week with a referral from the patient's doctor.
- Nursing staff on the acute stroke unit and on the medical assessment unit (Linnet) were trained to carry out a basic swallowing assessment for patients with difficulties eating and drinking. We saw one patient who had been admitted to the ward on a Saturday and was assessed as having a compromised swallow, which put them at risk of choking. No speech and language therapy staff were available to carry out a full assessment until Monday. As a result, this patient was kept 'nil by mouth' until the assessment could be carried out.
- We observed meal times on several wards and saw staff offered a variety of fluids and food to patients who needed help and encouragement. We saw staff helped patients to eat and drink when necessary.
- Staff on Falcon ward were positive in their comments about a team approach to ensuring patients received support with their nutritional and fluid intakes. The 'hostess' staff were quick to advise nursing staff of any concerns they had. On Jupiter ward, a focus on patient fluid intake had been put in place following two patient complaints and there was clear evidence from observation, patients' records and patients' comments that fluid rounds were taking place.
- Volunteers were working within the hospital and we spoke with one who told us they had received training to enable them to help patients with their meals.
- On some wards, including Jupiter ward, mealtimes were protected to ensure they were undisturbed and to promote good diet and fluid intake. Staff meeting records for this ward identified that this protected time was not being followed, with relatives visiting and doctors rounds taking place.
- On each ward we visited we saw patients had access to water and were helped to drink when needed. 'Hostesses' and volunteers were aware of a 'red jug' system for patients who needed extra help or encouragement.
- Some patients told us their dietary needs had been met; however, some patients felt there was too much food per serving.
- The Patient Led Assessments of the Care Environment (PLACE) 2015 showed the trust scored 84.89% for ward food. The comparative England averages were 88.30%.

## Patient outcomes

- In the Heart Failure Audit 2012/13 the trust performed better than the England average for three out of four indicators in hospital care and worse than the England average for five out of seven indicators in discharge. In the 2013/14 National Heart Failure Audit the hospital advised they delivered better in terms of medication in three out of four measures and delivered a high percentage of echocardiography. 100% patients had discharge planning. The trust advised that a local action plan was not applicable due to the nature of the recommendations
- The trust risk register included the cardiac rehabilitation service as failing to meet minimum standards. The service was benchmarked externally against the British Association for Cardiovascular Prevention and Rehabilitation, and the National Audit for Cardiac Rehabilitation Minimum Standards 2015. The trust advised that cardiac rehabilitation was not currently commissioned by the local commissioning groups, the trust advised that a second heart failure nurse had been recruited. The service failed on two counts (1) The programme was not offered to people with heart failure and (2) The duration of the outpatient phase three programmes was less than the national average. This risk was planned for review in October 2015.
- The trust performed worse than the England average for two out of three nSTEMI indicators in the previous two Myocardial Ischemia National Audit Programme (MINAP) 2013/14 audits and, for these two indicators, the trust's performance has worsened over time. Staff on the coronary care unit did not have a forum to

# Medical care (including older people's care)

discuss the results and senior staff recognised the data was not used as part of development discussion. A training session was planned with a speaker from MINAP to explain the results to all staff.

- The hospital performed better than the England and Wales average for 11 out of 21 indicators in the National Diabetes Inpatient Audit (NADIA); however, 10 indicators were worse than the England and Wales average. These included foot assessments within 24 hours, suitable meals, meal timing and choice. A clinical audit action plan was put in place and a follow up review was planned for September 2015.
- The Sentinel Stroke National Audit Programme (SSNAP) audits stroke services against evidence-based standards with a scoring of A to E, with E being the lowest score. The trust scored a level 'D' in the SSNAP audit (the second lowest level) but this was an improvement on previous quarters. The lowest scoring areas were around the stroke unit, specialist assessments, therapies and discharge processes. Key performance indicators for the trust showed that 66% of stroke patients were direct admissions and 53% were direct admissions within four hours, not meeting the 90% targets. Staff told us bed pressures had made the indicators hard to achieve and beds on Falcon ward were not protected. This meant the pressure to move patients out of the emergency department was greater than that to protect stroke beds for possible stroke patients. Records showed that, since April 2015, five patients were not admitted to Falcon ward (the dedicated stroke ward) and were admitted to other wards for care.
- An action plan had been implemented to improve the SNAPP score. This showed actions being taken but no timescale for completion. Actions taken so far included training more nurses in ED and MAU to carry out swallowing assessments, and a trial of seven-day therapy access that provided good outcomes but was subsequently stopped due to lack of funding.
- There was no occupational therapy (OT) access at weekends on Falcon ward and there was physiotherapy only for chest infections. The OT support was commissioned from an external provider. Staff commented that additional weekend OT support would benefit patients. A trial was held some time ago, which we were told had positive outcomes for patients

but had not been funded to continue. Occupational therapist input was prioritised to assess new patients within 72 hours but, due to therapist availability, complex patients and discharges were not seen.

## Competent staff

- Staff reported training was available for them to maintain their skills through electronic learning and through the trust's learning academy. However, some planned training was cancelled as staff could not be released from clinical work. Planned training for MAU staff on the day of our inspection was cancelled due to staffing shortages and busy wards.
- Ward staff were provided with training for their specific ward area. On Falcon ward, there was always one trained and competent thrombolysis nurse on duty throughout the 24-hour shift pattern. All nurses, with the exception of three recently recruited, were trained to ensure they were competent to insert cannulas and nasogastric tubes (a narrow **tube** passed into the stomach through the nose), as well as undertake venipuncture (taking of blood), and blood transfusions. Falcon ward kept a copy of the training record for each member of staff in their individual personnel file that was stored securely on the ward. On the MAU, newly qualified staff were trained to provide intravenous antibiotics to provide treatment for patients with infection.
- Healthcare assistants spoke positively of their developmental role and how training was provided to increase skills, knowledge and progression to a higher grade.
- Revalidation for medical staff took place. This is the process by which licensed doctors are required to demonstrate on a regular basis that they are up-to-date and fit to practice. Revalidation aims to give extra confidence to patients that their doctor is being regularly checked by the trust and the General Medical Council.
- There was no formal system to monitor and support staff with supervision or one-to-one coaching. Supervision is a vital tool used between an employer and an employee to capture working practices. However, the ward managers met with and worked with staff regularly on the ward and informal discussions were held. For example, feedback had

# Medical care (including older people's care)

been provided to one member of staff who was observed to work in a compassionate and holistic way when providing personal care to a patient. Staff commented they could approach their line manager and senior staff for support or guidance at any time.

- The NHS Staff Survey showed that in 2014 the trust was below the national average for the percentage of staff having well-structured appraisals in previous 12 months. Data provided by the trust on staff appraisal was incomplete. As a result, we could not be assured that they had a system in place that allowed the identification of staff who had received a regular appraisal to support their practice.

## Multidisciplinary working

- There was evidence of multidisciplinary working within and between wards and departments in the hospital. We observed a ward round on Neptune ward and a multidisciplinary meeting on the MAU. Time was initially spent in a private room around a white board, reviewing each patient. The process involved members of the multidisciplinary team of consultant, doctor, ward sister, nurses, auxiliary staff, therapists, occupational therapists and members of the discharge team. This was led by the medical team with input from all professionals. The process was detailed and informative.
- Staff on the medical wards reported that the critical care outreach team was supportive and provided a prompt and responsive service. Falcon ward (stroke ward) staff provided support throughout the hospital for patients who had experienced a stroke. We observed this in practice during the inspection with medical staff and nurse specialists providing care and treatment to two patients who were admitted to the emergency department.
- The stroke nurse specialist received telephone calls from GPs regarding patients they saw who had possibly experienced a stroke. During our inspection, advice was given to the GP to refer the patient to ED from where they were admitted to the stroke ward.
- The trust employed a coronary syndrome nurse who covered all areas of the hospital to review and highlight patients with acute needs. All staff who used this service spoke highly of the nurse employed and the

improvements created by having a staff member free to access patients throughout the hospital. The only consideration given was that this was a lone post with no support for out of hours, holidays and sickness.

## Seven-day services

- Consultants were available five days a week, some areas had seven day cover. These included cardiology who had a consultant ward round on CCU followed by in-reach to Mercury ward and LAMU. For wards with Consultant cover available midweek, they had on-call consultant cover available out of hours. There were three general medical consultants available to cover the medical assessment unit and one consultant covered the wards. These consultants undertook weekend ward rounds.
- On the MAU, staff confirmed that consultants carried out two ward rounds each day and that specialist consultants visited the unit when referred. Consultant rotas reviewed showed consultants mostly worked multiple-day blocks to maximise continuity of care.
- Once transferred from the acute area of the hospital to a general ward, patients were reviewed during a consultant-delivered ward round at least once every 24 hours, five days a week.
- Diabetes and stroke services specialist nurses, consultants, registrars, occupational therapists and physiotherapists were available Monday to Friday. Speech and language therapists were available on weekdays, but staff had limited access to therapists on a Saturday morning.
- The consultant who had responsibility for all outlier patients was available Monday to Friday, but registrars had access to the consultant on call at other times. We saw that weekend plans were in place for those patients to ensure a continuity of care in the consultant's absence.
- Endoscopy services were available on weekdays only. At the weekend, capacity was available for inpatients requiring urgent endoscopy for GI bleed, which was provided by an on call consultant. In order to improve the timeliness of the service, the department had

# Medical care (including older people's care)

been running additional elective weekend working since April 2014. This provided a minimum of four lists on a Saturday and one list on a Sunday, which ran every weekend (excluding bank holidays).

- X-rays and scans, and facilities for blood and specimen testing, were available seven days a week.
- Pharmacist support was available at weekends within working hours and on call out of hours.
- Psychiatric services were available on weekdays and weekends, with an on-call out-of-hours call line available.

## Access to information

- On admission to wards, paper notes travelled with the patient. The ward clerks then collated all information into a single record. This record was uploaded onto a computer and staff worked from the computer. Staff could access test results, care records and other information about the patient electronically from the wards. Medical staff worked from the paper record and all updates were added to the computer by ward staff. Nursing staff used nursing care records, which were accessible by the patient's bed, or if they were in a side room, the nursing care plan was stored outside the room. Staff told us this was for infection control purposes.
- We looked at 39 sets of notes; most contained sufficient information to inform staff of the medical care needed however, nursing care notes were not all detailed or individualised.
- Staff told us there were issues with sending letters to patients from the cardiology and rheumatology departments. The cardiology department told us that in an effort to get letters out on time, procedure appointment letters may precede the letters for any medically requested pre-operative checks, which needed to take place before the procedure. This caused confusion for patients as they were not aware that pre-operative checks were needed prior to their appointment. However, the trust has advised that no complaints or feedback had been received related to this issue. The rheumatology department saw patients in clinics and on the wards. We were told that letters were typed by the department secretary and sent out before the consultant had checked and signed them.

Rheumatology prescribing was mostly dealt with in the department and most letters were for information purposes. These letters included information about doses for medication, and any risk of error when transcribing may place patients at risk. However, the trust has advised that no complaints or feedback had been received related to this issue.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff received training on consent, the Mental Capacity Act 2005, and Deprivation of Liberty Safeguards. Overall training for this area was 73.9%, which did not meet the trust's target of 80%. 46.6% of junior doctors and 71% of respiratory medical staff had completed this training. Wards with a shortfall in this training included Teal, Jupiter and Mercury, and only 50% of respiratory specialist nurses had completed the training.
- We observed that verbal consent was sought from patients before providing personal care.
- The trust used Treatment Escalation Plans (TEPs) to identify a patient's choices for resuscitation. We saw that when a patient was identified as not having capacity to be included in the making of the decision to resuscitate, the appropriate assessments under the mental capacity act were not consistently completed. This meant the patient's best interests might not be appropriately considered in the decisions being made. We saw this on Jupiter ward and Neptune ward.
- On Neptune ward a TEP form decision for no cardiopulmonary resuscitation (CPR) was made by a consultant. The reason given was 'frailty, dependent on all activities of daily living and CPR would be unsuccessful'. There was no record of discussion with the patient or representative. However, later in the notes there was a faxed copy from the GP of an 'allow natural death' order in which the GP had recorded as the patient's wishes. A further patient on Neptune ward had a TEP in place and was considered not have mental capacity to make this decision. However, no mental capacity assessment had been completed. Despite the TEP form indicating the person lacked capacity, they had undergone a procedure without the capacity to consent and no assessment of capacity

# Medical care (including older people's care)

having taken place. There was no record of if a person close to the patient had been contacted, if this had been discussed with them, or if anybody was acting on the patient's behalf.

- In the records for a patient on the medical assessment unit it was recorded they lacked mental capacity but no mental capacity assessment had been completed. The rationale noted by the assessing doctor for the patient not having capacity was a list of medical conditions and not a considered rationale as to why those medical conditions would prevent them from having capacity to make their own decisions.
- The notes for one patient on Jupiter ward identified them as lacking capacity. A decision had been made to not resuscitate with a rationale of 'decision made in best interest', however there was no evidence of any family having been involved in this decision.
- The use of the TEP was new. The trust had decided that new staff employed from June 2015, the date at which decision was made to roll out TEP, would have training as part of the induction, life support training and mandatory training, including new doctors.
- There were 100 TEP 'champions' across the trust who had been trained by a member of the resuscitation team, spanning the acute hospital as well as in all areas of the community. Champions included consultants, ward clerks, nurses, radiographers and physiotherapists. The champions were currently rolling out ward-based training in each area to cover those employed in the trust before June 2015. The trust was unable to provide evidence of assurance that training was being carried out according to the plan as data would not be available until the end of November.
- Deprivation of Liberty Safeguards (DoLS) had been put in place on some wards. Patients with these safeguards in place were noted on the ward white board in the nurse's office. We looked at these patients' records, however nursing records did not give an indication that the safeguards were in place. We looked at four Deprivation of Liberty Safeguard forms that had been completed to ensure the patients' safety. Two of the four forms had expired without a review taking place. This meant that staff might have deprived those patients of their liberty

without legally being in a position to do so. No facility was in place to ensure the safeguards were reviewed and updated as necessary. We asked the ward sister how these safeguards were tracked to ensure they were appropriately reviewed before expiry. She advised this had been discussed but no action taken. MHA and MCA meeting minutes from June 2015 stated that a DoLS audit was scheduled but a date for that review was not included.

## Are medical care services caring?

Good



We found the service provided was caring and that the staff involved and treated people with compassion, kindness, dignity and respect. However, many patients told us that they did not know what the plan was for their care and treatment. They were not aware of the next stage of treatment and felt communication of this information was poor.

### Compassionate care

- During our inspection we saw patients were treated with kindness, compassion and respect and staff showed empathy to patients they cared for. Patients' dignity was promoted and we saw staff introduced themselves, speak to patients quietly and draw curtains when delivering personal care.
- Confidentiality was respected on wards with the use of whiteboards listing the names of patients in separate rooms accessible only by staff. Where whiteboards were located in public areas, confidential information such as the patients name, medical information and discharge arrangements was covered up.
- Patients were asked to comment on their experience in the hospital and particular wards and departments. We saw information displayed on patient feedback boards that showed patients had made positive comments. For example comments made on Neptune ward included "my care was excellent", "kind staff" and "professional and caring staff".

# Medical care (including older people's care)

- Friends and Family Test showed a response rate was similar to the England average. Individual wards provided the outcomes of this feedback for patients and visitors on each ward notice board.
- Patients told us how reassuring staff had been with an unsettled patient who constantly called out. They told us staff were never anything less than supportive and polite. One patient told us they had been a patient several times over the past few months. They were satisfied with their care and treatment and said "staff were kind, caring and went over and above the call of duty".
- The Patient Led Assessments of the Care Environment (PLACE) 2015 scored the trust at 92.4% for privacy, dignity and wellbeing. The comparative England average was 85.1%.
- When needed staff went the extra mile to support patient's needs. On Falcon ward staff arranged a wedding for a sick patient at short notice and supported them to be married on the ward. Bed managers, senior hospital staff and the chaplains were all involved in making this happen for patient.

## Understanding and involvement of patients and those close to them

- During our inspection we observed staff provided information to patients and their representatives regarding their care and treatment. One patient told us staff could not have been more helpful in explaining their treatment options to them. We saw one patient record that identified the patient's carer responsibilities at home. The records stressed the importance of ensuring the patient knew what the plan of care was to be.
- The National Cancer Patient Experience Survey showed that the hospital was below the national average for responses relating to understandable answers from ward nurses to important questions all/most of the time.
- Patients on Teal, Woodpecker and Jupiter wards told us that communication between the ward medical and nursing staff and the patient was poor. This left patients not knowing or understanding what was happening to them next, and what the plan of care and treatment was. We spoke with five patients on

Jupiter ward who confirmed they felt well cared for by staff but did not know what was happening next in their care and treatment. The exception was Falcon ward, when we asked three patients who all knew what their plan of care was.

- We observed doctors on Jupiter ward trying to communicate with a patient with hearing difficulties. As a result, the patient's treatment details were heard on the ward. The doctor tried using a pen and paper but was not successful; no other communication tools were used. The access to translation services was not well understood.
- The financial constraints meant staff only photocopied forms in black and white. Stroke care plans (provided to patients) when printed in black and white were difficult to read.
- The Patient Led Assessments of the Care Environment (PLACE) 2015 scored the trust at 84.8% for dementia care. The comparative England average was 72.60%.

## Emotional support

- We observed volunteers working within the hospital and saw one volunteer spending time chatting to patients on the elderly care wards.
- Chaplaincy support was available from both the hospital Chaplain and the Chaplaincy support team.
- A multi faith area was available for prayer and the Chaplain and his team were available for advice and support to all of the wards.
- Written evidence from relatives about the support provided to them during their relative's hospital admission included "staff on Mercury ward did all in your power to provide my mother with the care she deserved and had time to reassure us the family".

## Are medical care services responsive?

Good



Services were planned and delivered in a way to be flexible and meet the needs of the local population. Facilities and premises were appropriate for the services being delivered to patients with medical needs.

# Medical care (including older people's care)

Patients who required medical care and treatment were not always provided with a bed on a medical ward and medical outliers were admitted to surgical wards. Staff were aware of which doctors were providing medical care and treatment to medical outlier patients.

Complaints and concerns were addressed by the trust and taken seriously. Patients knew how to access complaints information.

Patients experienced delays in discharge and were unable to leave hospital when they were medically fit. A discharge team were in operation within the hospital working towards improving the discharge process for patients with complex needs. Difficulties in accessing packages of care in the community were delaying patient flow through the hospital

## Service planning and delivery to meet the needs of local people

- Patients were sometimes admitted to the hospital with compression bandaging in place. Staff on the wards did not have the skills and competency to undertake this type of dressing and so the tissue viability team would be contacted to provide this service. Staff confirmed that this was what happened under those circumstances.
- Ambulatory care was not a seven-day service. Acute physicians rotated through the unit and were supported by clinical staff. The unit was open Monday to Friday between 8am and 8pm. It is recommended that 30% of any medical take (emergencies) are seen through this unit but due to capacity issues and restricted opening times, this was not currently possible.
- The discharge lounge was open Monday to Friday between the hours of 8am and 4.15pm. Any patients attending the discharge lounge who would not be collected by 4.15pm would need to return to the ward they came from for collection. The criteria for patients to be transferred to the discharge lounge was limited. The discharge lounge was a very small space and staff were unable to electronically contact with all other areas of the hospital. Staff reported the greatest problem as accessing and completing discharge summaries. Three discharge summaries were still awaiting completion by consultants from July 2015. These discharge summaries were sent to the patients'

GPs and may include important information. Some patients left the discharge lounge before their take home medicines had arrived and the staff implemented a pick up system for relatives to return and collect them later.

## Access and flow

- The flow of patients through the hospital was managed in part by the site coordinators and through a series of bed meetings held throughout the day. Three meetings were attended by the senior operational management team and two by the management team again along with representatives from each ward and department. At these meetings, an update was provided along with a review of the bed occupancy rate. Discussions were held regarding the movement of patients through the hospital and the discharge arrangements in place. The last review of the hospital was held at 10pm and was attended by the on call site manager and the on call director for the trust. All data was gathered and recorded for the number of patients treated as outliers and when escalation beds were to be used. This ensured there was a good understanding of occupancy and flow issues.
- Two or three telephone calls with external partners were held each day to review potential discharges from the hospital and ensure arrangements were in place to support discharge. We observed two of the teleconferences that took place during our inspection and heard options discussed to speed patients discharge when possible, whilst respecting the patient's choices and wishes. Staff tried to accommodate patient's choices and preferences. In one case, consideration was given to moving a patient to another residential home as the original home was closed. This was discussed and rejected as an idea. Communication between the ward and the patient flow team was good. However communication and collation of information about who was referred to which external service by the discharge team who were not GWH staff, was not maintained. This meant hospital staff had to contact external services to find out internal information around discharge. This did not enable a clear vision for GWH staff to discharge activity for all GWH patients.

# Medical care (including older people's care)

- The site management team had electronic data showing the number of patients on each ward, the outliers, and patients in escalation beds. To help with the planning of admissions, it also showed the number of patients in the emergency department. They carefully considered the assessed care and treatment needs of patients who had not been admitted to the appropriate specialist ward. However, we observed that they were not always able to move patients to the ward that specialised in their care and treatment needs due to a lack of available beds in the speciality. For example, one patient who was a medical outlier was delayed in being transferred to the ward that specialised in their care and treatment as another patient with complex needs was prioritised for the next available bed.
- Escalation beds, to be used at times when the hospital was busy, were in place on certain medical and surgical wards. Escalation status was considered throughout the day and was communicated via daily site team reports. There was a policy in place to advise staff of how and when to escalate concerns. The identification of escalation was rated between green and black, with green being business as usual and black being the trust in a critical position with patient safety compromised. During the inspection, the rating dropped from red to amber.
- Discussions were held at bed meetings regarding how best to use escalation beds and where outliers were placed in order to support the wards and departments involved. For example, careful consideration was given to medical patients who could not be admitted to a medical ward and which area of the hospital would best meet their needs without compromising the patients and staff already on the ward or department. At our unannounced inspection, there were ten medical outliers in the surgical assessment unit and nine medical outliers on Beech ward (a gynaecology ward). These outliers had been assessed as safe to be on those wards.
- For those patients receiving care and treatment in outlier beds, a dedicated consultant and registrar team had been put in place to ensure they were seen promptly and their care managed. The consultant in charge visited all of these patients and ensured no patients were missed. Staff knew how to contact the doctors and how to raise concerns about care and treatment. We were made aware that the consultant post was about to become vacant, senior staff assured us they were reviewing how this would be managed however, staff voiced concerns about the risks to patients if the current standard of service was not maintained.
- Patients told us that in the majority of cases the journey from admission to the correct ward had been well managed with very few changes of ward having taken place. However, transfer at night took place. Night was considered to be between 11pm and 6am. The trust did not include in its data those admission transfers through the Medical Assessment Unit (Linnet) or medical admissions direct to the ward. Between April and September 2015, the monthly amount of night time transfers varied from 310 to 424. Patient discharges at night varied from ward to ward with the highest amount being from the Medical Assessment Unit (Linnet) with low numbers from the remaining medical wards.
- We saw on the dementia friendly ward the review of 17 patients during a multidisciplinary meeting identified only four patients with dementia. The remaining patients were receiving general medical care.
- Whilst staff recognised they worked hard to increase the flow of patients through the hospital, they did not know how else to improve the situation.
- Staff were proactive in managing patient discharge. Discharge planning sheets highlighted which patients were due for discharge and any tests or treatments that were required prior to that happening. Neptune ward had a coordinator who supported staff with the discharge process by ensuring medical staff had prescribed medication to take home and paperwork was in place.
- The discharge lounge was open Monday to Friday between the hours of 8am and 4.15pm. There were low numbers of patients using the discharge lounge, due to the criteria for use, open hours and location. However, patients who used this lounge were pleased with the service. Plans for the development of the discharge lounge were unclear to staff. Clear criteria were in place that patients had to meet in order to be accepted to the area including no patients who were

# Medical care (including older people's care)

confused or bedbound. If staff were unsure whether a patient was suitable for the discharge lounge a nurse from the area went to assess the patient on the ward. Discharge lounge staff went to the ward to collect patients but at times ward staff were required to transport patient to the discharge lounge if staffing levels were low.

- There was a backlog of patients waiting for endoscopy. Remedial action had taken place to address this through increased clinics at the weekends and recruitment of gastroenterology consultants. This had shortened the waiting list.
- Patients who may have suffered a stroke followed a specific stroke pathway. The pathway identified that patients who had received thrombolysis treatment were admitted to Falcon ward, even if this meant moving somebody from Falcon ward to another medical or outlier ward. Following assessment, if possible a stabilised patient was moved from the stroke ward to free a bed. The stroke pathway was not followed for one patient who had been admitted to the medical assessment unit following thrombolysis in ED. An incident form had been completed regarding this incident and the risk to the patient.
- Over half of all patients we spoke with had one or more ward moves during their admission. The patient journey included the emergency department, the medical assessment unit (Linnet) then to a ward. Most patients told us they had taken this path.
- We saw that on Teal ward, short stay older people's beds facilitated a quicker discharge. There was also access to therapy teams in the hospital and on discharge in the community. There was a geriatrician consultant on rota of the day to see all new admissions and an in reach consultant who would review patients on the medical assessment unit to ensure a shorter patient stay if possible. The projected length of stay for this ward was 14 days. Staff said the short stay ward was not utilised well. At the time of our inspection eight out of ten patients were not short stay as they were delayed discharges waiting for packages of care in the community.
- The weekly rate of patients fit for discharge from medical wards varied; in September 2015 it went from a weekly rate of 51 to 68 patients.

- The trust met the 90% standard and was higher than the England average for percentage of patients treated within 18 weeks of referral to treatment time (RTT). Every speciality met the 90% RTT standard for the reporting April 2013 to April 2015.
- Overall, the average length of stay was lower than the England average. However, the length of stay for elective clinical haematology was 11 compared to the England average of 8.8. Elective and non-elective cardiology were higher than the England average. Elective cardiology was 2 compared to the England average of 1.7 and non-elective was 7.5 same as the England average.
- Demand currently outweighing the capacity for the stress echo service resulting in breeches of the six-week diagnostic target. There was only one Cardiologist who could undertake stress echo testing which was a risk as the service would be disrupted if they were not available. This was identified on the trust risk register with a review date of January 2016. A previous risk register identified extra clinics had been included to meet the targets.
- Some cost saving measures had compromised care. There was a blanket policy for second class post. As a result some patients did not receive MRSA washes or preparations for endoscopy procedures in time and consequently had their procedures delayed. These issues were raised with the trust during the inspection.

## Meeting people's individual needs

- All areas of the hospital had access to leaflets and literature about the services available. These leaflets were in English but staff told us translation services were available by telephone should they be needed. Staff demonstrated a varied understanding of the translation services available with most staff saying they were not used often.
- We saw that when needed a Halal menu was available; translation was available for the patients' whose first language was not English. The hospital intranet held information for staff about religious and cultural preferences.

# Medical care (including older people's care)

- Hearing loop services were available on the wards for patients who had hearing difficulties. The hospital had facilities in place for patients with mobility aids and corridors were wide with ample access by lifts.
- Patient's relatives were able to stay on the ward but no specific accommodation was available. Some wards had a day room with a couch, which staff told us could be used if circumstances called for it.
- The trust had a dementia care strategy in place for staff to follow. Dementia training was provided by electronic learning. Jupiter, Saturn and Teal wards did not meet the 80% training target for all staff to have achieved this training by July 2015. Shortfalls were also seen in training by cardiology medical staff 66.7% gastroenterology 72.7 %, neuro 66.7% and respiratory specialist nurses 50%.
- A dementia champion had been organised on Jupiter ward and was being supported by the hospital training academy. Their role was to support other staff and cascade learning in dementia care. At this time dementia specialist nurses were not employed at the hospital. The RCN recommendations 'Scoping the role of the dementia nurse specialist in acute care (2013)' recommends there should be at least one whole time equivalent dementia nurse specialist for every 300 admissions of patients with dementia per year. The ward manager confirmed 1500 hospital admissions last year for patients with dementia.
- The measurements for success of the dementia friendly ward had been undertaken after six months and Woodpecker ward had been used as a comparison. Further review at 12 months was intended to give a true picture of benefits for the dementia friendly refurbishment. Initial findings indicated a downward trend for patients with dementia falling on Jupiter ward.
- The trust employed a team of specialist nurses to support patients living with a learning disability. Nursing staff on wards were positive in their comments about this service. We were told that on occasions when they had required additional support for patients they had received a prompt and helpful response.
- The community learning disability services had an in reach service, providing support to patients in hospital. A learning disability awareness week was planned for November 2015. Easy read information was made available for patients with a learning disability to include x-rays and blood results. On admission to hospital, an alert system was in place to enable staff to make all adjustments needed to support the patient.
- Stroke therapists, consultants, doctors and specialist nurses provided care to outliers on other wards. If a patient was already an inpatient on another ward and identified as having a stroke, the stroke team visit them on the ward to provide advice, guidance and support until such times the person could be transferred to the stroke ward
- Call bell response times varied from ward to ward. Response times were recorded electronically and an overall percentage score was seen on each ward notice board. In the period of May 2015, we saw that the majority of call bells were answered in all areas within five minutes or less. Response times between five and 15 minutes varied from ward to ward with Saturn and Woodpecker wards having the highest amount of responses in this time bracket and Falcon ward having the lowest number. Responses between 15 and 45 minutes were seen to be highest on Falcon, Neptune, Jupiter and Woodpecker wards. A small number of responses were seen to be over 45 minutes, with the highest being recorded on Saturn, Woodpecker and Kingfisher wards. A call bell response times action plan had been produced by the divisional matrons with actions that included monthly unannounced senior nurse inspections. We observed call bells being used and saw that they were mostly answered in a timely manner. All patients were seen to have access to a call bell to alert nursing staff.
- For patients who required heart monitoring, a home monitoring system had been initiated. Medical staff told us there was supportive data on the reduction of mortality and morbidity and reduced attendance at pacemaker clinics.
- Clinical specialist nurses were available within the hospital. The stroke nurse practitioner visited patients across had a stroke to enable the specific stroke needs of those patients to be met.

## Learning from complaints and concerns

# Medical care (including older people's care)

- Information was seen on wards to inform patients on how to make a complaint. Some patients were aware of how to complain, though not all we questioned.
- Clear evidence was seen of how complaints were investigated at ward level with feedback and apologies given to the complainant.
- We saw evidence that learning from complaints was shared across the trust. We reviewed the investigation into a complaint that had been received on Mercury ward. The outcome from one complaint investigation was shared at the ward team meeting, directorate ward managers meeting, infection prevention and control forum, patient safety and control forum and at the unscheduled and community care directorate community meeting, ensuring learning was widespread.
- The trust board reports for August 2015 showed they had received 11 high to extreme complaints. There were seven re-opened complaints. One new complaint case had been taken on by the Parliamentary Health Service Ombudsman (PHSO) and ten cases were awaiting outcome from PHSO investigations and two cases were being considered for investigation by PHSO with three cases investigated by the Ombudsman with recommendations made.

## Are medical care services well-led?

Requires improvement



Staff were aware of the vision and values of the hospital. They were confident at ward level about the leadership of matrons and managers. They felt supported by management at that level. Few had understanding or awareness of the hospital above that level.

The effectiveness of the divisional governance system was not evident in some areas. Some areas of concern had not been identified and actioned.

Senior management were not always felt to be visible. The NHS staff survey results for 2014 showed that the trust was below the national average for staff who staff reporting good communication between senior management and staff.

There was some misunderstanding outside of ward areas of the level of care provided on the Coronary Care Unit and Mercury ward. This does not ensure clear leadership of the medical service.

## Vision and strategy for this service

- Staff were aware of the vision and values of the hospital. They were not all aware of the hospital executive board members. A short while before the inspection, non-executive members of the board had visited some wards. Staff invited them to spend a day on the ward, however staff told us nothing more had come from this invitation.
- The coronary care unit had incorporated their specific philosophies of the Coronary Care Unit into the hospital's visions and strategies and these were displayed on the unit for staff to see.

## Governance, risk management and quality measurement

- The governance structure for the medicine division was through a series of committee meetings. The Department/Ward meetings, Speciality Mortality and Morbidity Meeting, Speciality Clinical Governance Meeting, User Group Meeting and Speciality Working Groups all fed information to a senior sisters meeting. From there the information went through monthly matrons meetings, patient quality committee and governance meetings to the board of directors.
- Information was cascaded from the board of directors to the executive committee and then on to the divisional board, the sub divisional management team meeting, Clinical lead/Matron/Head of Service and care consultant meetings before arriving back at the department ward meetings. This process was in place to enable a flow of information from ward to board and back again. Staff told us they felt information went up the process but was lacking in feedback and response when issues were raised.
- The effectiveness of this governance system was not evident in some areas. We saw that areas of concern had not been identified and actioned. For example, the management of the Deprivation of Liberty Safeguards did not have systems in place to identify when the safeguards were about to expire. We spoke with a senior nurse who confirmed this had been

# Medical care (including older people's care)

discussed but not action put in place. Shortfalls in the completion of Treatment Escalation Plans and mental capacity assessments affected patients' choices and decisions. The trust had put systems to develop training however, in the interim, it was evident that the systems did not ensure patients safety. It had not been identified that patients at risk due to mental health issues were being cared for in an inappropriate environment and that staff and patients safety was ensured.

- Staff told us that they were confident that the information about quality measures and audits completed were fed up to division level. However, they were not confident what was done with it and that outcomes or related information came back to them.
- Risk registers were in place and staff showed awareness of issues that had been raised and identified on the ward risk register. They told us that they were encouraged at ward level to raise issues to go onto the risk register, though they had a limited knowledge of what happened to the risks after that point.

## Leadership of service

- The medical wards and departments came under the divisional group of 'Unscheduled Care'.
- A clear management structure was in place within the medical division with leadership provided by ward sisters, ward managers, matrons and divisional nurse leads and Divisional director of Nursing.
- Staff were positive about the leadership arrangements that were in place locally to them. We heard that ward managers and matrons were approachable and accessible to the staff and were visible on the wards. One ward sister described the support provided by their ward manager to develop leadership skills through the completion of a leadership programme.
- Staff told us they understood the whistleblowing policy and would feel able to raise concerns if needed.
- Senior management were less visible. The NHS staff survey results for 2014 showed that the trust was below the national average for staff who staff reporting good communication between senior management and staff.

- There was some disconnect between divisional management and ward level. This included the understanding of level 2 care on the coronary care unit and Mercury ward. The risk register stated that Saturn ward provided level 2 higher dependency care. Staff told us that level 2 care was not provided. The Coronary Care Unit however stated that they provided occasional level 2 care.

## Culture within the service

- While staff were proud to work at the hospital staff satisfaction appeared mixed. The pressure of staffing constraints and the management plan of moving staff between wards to diversify skill mix had been met with discontent by staff.
- Staff told us they felt able to raise a question to the board and that the culture was open to suggestions for improvement.
- Some staff awards schemes were in place to reflect when areas were doing well
- Staff confirmed that Matrons and managers worked at least one clinical shift each month to ensure an awareness of ward culture and any issues for staff.

## Public and staff engagement

- The NHS staff survey results for 2014 showed that the trust was below the national average for staff who thought that feedback from patients/service users was used to make informed decisions in their directorate/department.
- Patients and visitors to wards and departments were asked to provide feedback on their experience. We saw comment cards were available in prominent places for example, at the entrance to wards and departments.
- Feedback boards were in place on wards. We saw information on Neptune ward that showed feedback had been received and action taken by the ward in response. For example, one person had commented that they could not find the doorbell to access the ward. A poster had been printed and placed next to the doorbell to make it more prominent.
- We saw that the hospital recognised staff performance and achievement. Awards included Team of the year

# Medical care (including older people's care)







awarded to the site management team in 2014 and team of the year awarded to Falcon ward in 2013. The Coronary Care Unit was in the running for the second time for best student nurse placement.

- We were also told that Avon, Gloucestershire, Wiltshire and Somerset Cardiac and Stroke Network awarded Falcon ward a place on the accelerating stroke improvement incentive scheme trajectory in 2012.

## **Innovation, improvement and sustainability**

- We saw a number of areas where innovative practice had taken place. Staff told us they felt encouraged and welcomed to share ideas to improve the quality of care provided to patients and felt listened to by senior ward staff.
- The trust were undertaking a number of projects that will impact on the service for older people, including a proposed ward accreditation programme the accreditation programme was approximately two months away from ratification.
- Staff on Falcon ward told us there had been a new type of mouth care sponge used on the ward with patients who had swallowing difficulties. The sponge enabled suction to be attached which reduced the risk of choking and improved the patient experience. However, staff had used ward funds to purchase the sponges and had put forward a request to the trust for funding for the equipment. They had been waiting for two months for a response. Soft toothbrushes and non-foaming toothpaste had also been purchased on the ward to reduce risk and improve patient experience. At the time of our inspection there was a re audit in process to establish effectiveness of the toothbrush.
- There were plans in place to develop safeguarding champions trust wide to include dementia, safeguarding, learning disability and mental health. These were not yet in place.

# Surgery

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

## Information about the service

Great Western Hospital provides a range of surgery and associated services. The surgery teams sat within the 'planned care directorate' which included a small number of services written about elsewhere in this report.

The hospital had a main theatre unit (inpatient and day-case surgery) with 15 operating theatres, and a separate day-case operating theatre for oral and maxillofacial surgery (surgery associated with the mouth, jaw, face and neck). There was a day surgery unit for patient admission and recovery with eight beds, two side rooms, and an area for five trolleys for recovery. The area also had a large room with reclining chairs for patients well enough to stay until they were able to go home.

Surgery included general, urology, trauma and orthopaedic (including spinal and head injuries), breast, colorectal, ophthalmology, and maxillofacial, including orthodontics. Surgery was provided as both elective (planned) and in an emergency. The hospital also carried out interventional radiology: a process of using minimally invasive image-guided procedures to diagnose and treat diseases.

The hospital had four main surgery wards located in the Brunel Treatment Centre, which was opened in 2005: three years after the main hospital. Aldbourne, a 24-bed ward for patients predominantly having planned or elective orthopaedic surgery; Ampney, a 20-bed ward for patients having urology or minor vascular surgery; Meldon, a 36-bed ward for patients having emergency or general surgery; and the Trauma ward, a 28-bed ward for patients having trauma or orthopaedic surgery. There were also female breast

surgery patients cared for in Beech ward (gynaecological and breast surgery ward) in the main building. The Shalbourne Suite was the trust's 19-bed private surgical unit used for both NHS and privately-funded patients.

Surgery services also provided a pre-operative patient assessment unit (Cherwell) and a surgical assessment unit for patients coming either through the emergency department or admitted via their GP. Other services included two post-operative recovery areas for 22 adult patients and four children, a theatres admission lounge for orthopaedic patients, a theatre stock team, and hospital sterile and decontamination services.

On this inspection we visited the surgery services on Wednesday 30 September, Thursday 1 and Friday 2 October 2015 and made an unannounced visit for the day on Sunday 11 October 2015. We visited all the surgery wards, main theatres and the two recovery areas (including meeting the theatre stock team), the oral surgery unit, Cherwell pre-assessment unit, theatres admission lounge, the day surgery unit, surgical assessment unit, and hospital sterile and decontamination services. We spoke with staff, including nurses and healthcare assistants, the main and day-case theatre managers, and the manager of the post-operative recovery units. We met the head of nursing for surgery, senior managers, one of the ward matrons, ward sisters, consultants, senior doctors, and junior doctors. We also talked with pharmacy staff, housekeeping staff, and physiotherapists. We met with patients and their relatives and friends. We observed care and looked at records and data.

# Surgery

Great Western Hospital carried out around 29,000 operations in 2014. Of these, 51% were carried out as day case procedures, 18% as inpatient elective (planned) cases, and 31% as inpatient emergency cases.

## Summary of findings

We have judged surgery services overall as requiring improvement.

Nursing staffing levels were leading to patients not being provided with quality and safe care at all times. There had been a significant breach of patient record confidentiality with confidential medical records left in the unoccupied and unlocked day surgery on a weekend. The hospital trust took urgent action and rectified this situation. We received a full and satisfactory report of the remedial action taken.

Not all incidents were being reported to enable them to be investigated and responded to and mortality and morbidity reviews did not demonstrate how the service was focused upon improvement to quality and safe care. Staff updating their mandatory training was not meeting trust targets.

Safety was good within operating theatres. Most areas of the hospital were clean and infection prevention and control protocols followed, although audit results were contradictory. Medicines were mostly safely managed, as were equipment and the environment. There was a safe level of cover from the medical staff.

Length of stay in the hospital was better than the England average. Patients' pain, nutrition and hydration were mostly well managed with specialist input when needed. Staff were skilled and experienced, although not all had received an annual performance review. There was strong multidisciplinary input to patient care. Important services were provided seven days a week and there was good access to information.

Feedback from patients and their families had been positive overall. The Friends and Family Test produced excellent results. Patients we met in the wards and other units spoke highly of the kindness and caring of all staff. Staff ensured patients experienced compassionate care, and worked hard to promote their dignity and human rights, even though this may have failed at times. The main criticism was staff not having the time to provide more than basic care at times, although wanting to provide a higher standard.

# Surgery

The use of the day surgery to admit patients meant not all their needs were being met. The hospital was in a period of failing to meet the referral to treatment times for almost all surgery specialties and waiting times were worse than average. Bed occupancy was high and patient access and flow was poor at times. The hospital was regularly faced with a high number of patients who were fit for discharge, but without transfer of care packages. Cancelled operations were low, and the pre-admission, admission and discharge services provided good support.

The more complex needs of patients were met, but there was little innovative support for patients living with dementia within the surgery wards. Complaints were addressed, but the evidence of how they improved the quality and safety of care was limited.

The service lacked a cohesive clinical governance structure demonstrating learning, change and improvement. There was good leadership and local-level support for staff. All the staff we met showed commitment to their patients, their responsibilities and one another. There was a strong camaraderie within teams. We were impressed with the loyalty and attitude of the staff we met.

## Are surgery services safe?

Requires improvement



We have judged the safety of surgery services as requiring improvement.

There was a lot of good and safe practice, but nursing staffing levels were leading to patients not being provided with quality and safe care at all times. There was also a significant breach of patient record confidentiality with confidential medical records left in the unoccupied and unlocked day surgery on a weekend. The hospital trust took urgent action and rectified this situation. We received a full and satisfactory report of the remedial action taken.

Staff were open and honest about incidents but some were not being reported as they should. Patient mortality and morbidity were reviewed but the accountability for any actions from where improvements should be made was not decided, or revisited to look for improvements. There had been significant improvements in the use of, and respect for, the World Health Organisation surgical safety checklist. The wards were open with their publication of avoidable patient harm, for which incidents were variable, but high on wards with frail confused patients. Most of the wards and units we saw were clean and infection protocols were followed, but audit data was unclear. Staff were updating their mandatory training, but not meeting trust targets.

Medicines were mostly well managed, stored and administered safely, but medicine reconciliations were not being achieved in line with guidance or trust policy. There was a good range of safe and well maintained equipment, although some decontamination and sterilisation equipment was becoming unreliable. The majority of patient records were completed well. There was a clear and well-followed process for responding to acutely ill patients and an experienced and skilled staff team providing pre-operative assessment. Overall, there was safe cover from the medical team.

### Incidents

- The trust acted upon significant incidents. The trust had reported one Never Event in surgery services in the last 12 months (March 2015). This related to a retained foreign-object following an operation. A never event is a

# Surgery

serious, wholly preventable patient safety incident that has the potential to cause serious patient harm or death. In this event, no harm came to the patient, but there was an identified failing in the correct use of an early part of the World Health Organisation (WHO) surgical safety checklist. The WHO checklist is an internationally recognised system of checks designed to prevent avoidable harm during surgery procedures. The root-cause analysis report into the event in surgery contained clear details and the investigation was conducted by a consultant unconnected with the incident. The failing within the use of WHO checklist was identified and a change to practice instigated to avoid future recurrences. One of the recommendations of the investigation was how the responsibility for the use of certain necessary packs in surgery should be clarified. The change in responsibility was made clear in the trust policy for swab, instrument and needle counts, which was implemented in June 2015. Of the other serious reportable incidents, there were 18 in the report from May 2014 to April 2015 related to surgery services. Of these, nine were patient falls with harm.

- All staff we met were open and honest when reporting incidents. However, there was a problem with some staff admitting they were often too busy to do so always when required. There were also some incidents that had become 'routine' for some staff and these were therefore not getting reported. This included patients waiting many hours for medicines to take home before being able to leave; staffing shortages on the wards; some near misses; and patients being held in recovery due to an excessive wait for a ward bed.
- The majority of staff we spoke with in theatre, units and wards said there were no barriers to reporting incidents, apart from the time to do so. They said they were encouraged and reminded to report incidents by senior staff and most received feedback. Staff in the theatre admission lounge (TAL) did say, however, they were too busy to report anything other than the most pressing or serious incidents. They said, for example, they were not reporting changes to operating lists, which would be classed as incidents, due to time pressures. On the other hand, staff on the Trauma ward said they believed they were good at reporting incidents and it was ingrained.

On our unannounced visit to the Trauma ward we observed from records how a frail patient had suffered a fall. We asked staff to demonstrate if this had been reported as an incident and we saw it had.

- A number of nursing staff we spoke with on the wards said they no longer reported staff shortages. A number said the same thing which was: "it does not make any difference to report it". Some staff on the wards commented upon how they always prioritised patient care over reporting where there were problems. One nurse on Aldbourne ward said: "if I have a patient who needs help and an IR1 (the trust incident reporting system) to do, the patient comes first always, and then sometimes the moment (to report the incident in question) has gone." The trust, overall, was slightly below (lower than) the NHS England average for reporting incidents. This could be taken as an indicator of under reporting of incidents by staff.
- The staff comments above were supported by data showing the top 10 reporting departments from January to August 2015 were the Trauma ward followed by theatres. The other surgery wards, Aldbourne, Ampney and Meldon, were showing as relatively very low reporters and theatres admission lounge was not mentioned in the top 10. The top reported incidents included falls, staff shortages and pressure ulcers.
- Patient mortality and morbidity (M&M) was reviewed by the surgical teams, but with variable input and content, and insufficient evidence to show how agreed actions were delivering improvements. Also, patient deaths were not categorised under the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) five classifications. This would provide staff with data to determine how many deaths had taken place within nationally recognised categorisations. The M&M meeting minutes did not demonstrate if or how staff were accountable for all actions agreed from reviews or demonstrate improvements from actions taken. We reviewed sets of minutes provided for the general surgery division, the orthopaedic division and one from urology. The findings were:
  - The minutes from general surgery reported areas of good practice followed by key issues and recommendations. There was good attendance but the regularity was variable among the consultants, with some attending most meetings and others very

# Surgery

few or none. Actions agreed related only to administrative matters and there was nothing in the minutes indicating any learning to improve patient outcomes.

- The urology meeting (we were sent one set of notes) was well attended, although the minutes suggested the meeting was held infrequently, or not always minuted. There were, it should be noted, infrequent deaths within this division to discuss, and discussion related more to morbidities. The recommendation from this meeting did relate to improving a patient pathway, but there was no deadline to complete the agreed action.
- Duty of Candour had been introduced to staff. Those we talked with were aware of the new regulation to be open, transparent and candid with patients and relatives when things went wrong, and apologise to them. From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to incidents or harm categorised as 'notifiable safety incidents'.

## World Health Organisation Surgical Safety Checklist

- The hospital used the internationally recognised WHO surgical safety checklist in all surgical procedures. As recommended by the NHS National Patient Safety Agency (NPSA) it had been adapted for more specific use in areas such as emergency surgery, ophthalmology, and for patients being given a local anaesthetic. The hospital adopted the use of the checklist as part of the introduction of the NPSA 'Five Steps to Safer Surgery 2010' guidance. This extended practice in operating theatres to include a briefing at the beginning of a surgical list and a debriefing before members of the team left the theatre or department. The practices were now well embedded following criticism of implementation of the Five Steps and the WHO checklist from the Care Quality Commission in late 2011. The Commission found significant improvements in mid-2012, and this had been sustained.
- The hospital was performing well in a regular audit of the WHO surgical safety checklist in main theatres, although a few areas had been recognised as needing improvement. There was no audit data for non-standard procedures (ophthalmology and local anaesthetic) but

this had been recognised and was being addressed with audits to be completed before the end of 2015. Overall compliance for standard checklists for the year 2014/15 was 96%. This remained the position in quarter one of 2015/16. In the first half of 2014/15 the audit had only been reviewing 20 records each quarter. This was therefore a small proportion of those procedures carried out. This has now increased more than five-fold to around 110 records each quarter. The audit was extensive and looked at 56 different indicators. The most consistently good results over the 15 months from April 2014 to June 2015 were from the surgeon checks being completed. One area not showing much improvement was in the one-fifth of procedures carried out involving regional anaesthetic. Not all of the checks recorded if a 'stop' (a pause in proceedings) was performed before the regional anaesthetic was administered. The only consistently poor area was with the legibility of the sign-out checks for which 51% were considered acceptable in April to June 2015. The average of the 15 months from April 2014 to June 2015 was 47%.

- We observed good practice in the operating theatres, with staff adhering to those parts of the WHO checklist protocol that we observed. All staff involved were present and included. There were no distractions. We observed practice and felt it appeared 'natural' (not being performed for our benefit) and well embedded. The hospital had recognised, however, there was considerable detail in their WHO checklist so it had recently been redesigned in favour of a streamlined version, which would be rolled out shortly when the printed copies were produced.
- Staff were provided with information on the performance against the Five Steps and WHO checklist. There was a dedicated notice board in the main operating theatre suite with the latest audit report and results displayed.

## Safety thermometer

- The surgery inpatient areas had a variable picture of avoidable patient harm when measured across a whole period (as opposed to one given day in a month as per the safety thermometer data below). The number of falls was variable but had not shown any improvement. In the surgery wards, including the Shalbourne Suite there had been 23 falls in June, 16 in July and 19 in August

# Surgery

2015, although none leading to serious harm. The incidence of pressure ulcers was shown as increasing. There had been none of the more serious category (three and four) in June, but three in July and two in August 2015.

- As required, the hospital reported data on avoidable patient harm to the NHS Health and Social Care Information Centre each month. This was nationally collected data providing a snapshot of avoidable patient harms on one specific day each month. This included hospital-acquired (new) pressure ulcers (the two more serious categories: grade three and four) and patient falls with harm. The report also included catheter and urinary tract infections (UTIs) and incidence of venous thromboembolism (VTE). Within this snapshot view, the hospital trust had a relatively similar monthly pattern of harm-free care in the 12 months from August 2014 to July 2015 and an average overall of 94% of harm-free care delivered for 5,822 patients. On a more detailed level, pressure ulcers and incidence of VTE were increasing, but falls and catheter/UTIs were falling.
- At surgical ward level, Aldbourne ward had the best performance in the snapshot view. It had 10 out of 12 months of 100% harm-free care. The surgical assessment unit had eight months with 100%, but the Trauma ward, with mostly frail older patients, had not achieved 100% in the 11 months since it opened in a new configuration in September 2014.
- There were public displays of the results of avoidable patient harm data on the wards. The wards were open about their patient care data, and displayed when they had last treated a patient with a hospital-acquired pressure ulcer or a patient had a fall with harm. A number of the ward staff did point out, however, they were displaying information for patients with pressure ulcers who had been admitted with these, as opposed to them developing on the ward. Staff felt this misrepresented the quality of care they provided.

## Cleanliness, infection control and hygiene

- The ward areas of the hospital we visited were mostly visibly clean, tidy and well maintained. This included patient bed spaces, corridors, staff areas and equipment used both regularly and occasionally. Patient bed spaces were visibly clean in both the easy and hard to

reach areas such as beneath beds and on top of high equipment. Bed linen was in good condition, visibly clean and free from stains or damage to the material. Storage cupboards were well organised with most equipment on shelving units to prevent dust and dirt gathering around and beneath objects. Several patients we met on the wards said the cleaners were regularly seen. They were seen dusting at height (such as curtain rails), washing floors, and cleaning under beds with damp cloths.

- The one area not effectively cleaned was the day surgery unit ward area when we visited on our Sunday unannounced inspection. There was debris on the floor, the female toilet was not clean on the floor and there was a (clean) hygiene product on the back of the toilet bowl. There was only one bed (of a possible eight) in the room so the area was not in use. However, the clinical site manager assured us the area should have been cleaned and could be required to open for escalation that day. The clinical site manager contacted the housekeeping team and arranged for the unit to be cleaned urgently.
- The operating theatre areas we visited were visibly clean, well-organised and maintained. The recovery rooms were able to be effectively cleaned at the start of the day as they were empty of beds. There was regular audit by the external company providing cleaning services. However, staff said the results of these audits and action plans were not shared with the unit.
- There were low levels of methicillin resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile* (C-diff). There had been no MRSA in surgery areas from January to August 2015. There had been two incidents of C-diff in April, one in May and one in August 2015.
- The data supplied to us to demonstrate infection control audit raised uncertainties. We requested evidence of environmental audits to demonstrate how infection prevention and control and cleanliness was monitored. We were sent a sample of hand-written audits from various wards. Alongside this was an infection control summary audit for all wards areas. Areas of uncertainty in how these were reported were, for example (but not limited to):
  - In the day surgery matron audit (completed alongside infection prevention and control staff)

# Surgery

dated 15 May 2015, the unit scored 47% and highlighted issues with cleaning of drip stands and dusty areas. In the trust infection control departmental self-audit report for May 2015, day surgery scored 94% for the cleaning score, 100% for everything else including patient equipment, and none of the issues in the matron audit were reported.

- In the surgical assessment unit (SAU) managerial audit (completed alongside infection prevention and control staff) dated 11 June 2015, the unit scored 54%. In the trust infection control departmental self-audit report for June 2015, the SAU scored 96% for the cleaning score and almost 100% for everything else. This included a score of six out of seven for hand gel availability despite there being no hand gel available in the three areas audited in the managerial audit.
- In the Meldon ward matron audit (completed alongside infection prevention and control staff) dated 20 May 2015, the unit scored 51%. In the trust infection control departmental self-audit report for May 2015, Meldon ward scored 94% for the cleaning score and 100% for everything else.
- In the Trauma ward matron audit (completed alongside infection prevention and control staff) dated 24 June 2015, the unit scored 79.6%. The ward was marked down for there being dirty commodes. In the trust infection control departmental self-audit report for June 2015, Trauma ward scored 100% for all elements.
- In the managerial audit of theatres (completed alongside infection prevention and control staff) dated 18 June 2015, the unit scored 77%. The action plan said the external cleaning “failures” had been corrected. In the trust infection control departmental self-audit for June 2015, the cleaning scored 99%.
- There was an accredited hospital sterilisation and decontamination unit (HSDU). The unit operated from 7am to 11pm Monday to Friday and 9am to 5pm on the weekends. There was a 24-hour on call service. The unit was recently audited by an independent organisation where it was rated within the top 10 units in the country for quality management systems. The staff responsible for the instruments worked with high degrees of concentration and stamina. They were rotated from their tasks every two hours to ensure they had a change of focus. There was an issue on the unit with the ageing steam generators breaking down. This had been elevated to the risk register. During the inspection there was an incident with specialised fluids not being delivered to the hospital sterilisation and decontamination unit due to issues with payment. This was resolved, but the risk register highlighted this had been as an issue since 2013. The review date was in November 2015 and therefore two and a half years since it was first raised.
- All the staff we met and observed followed infection prevention and control protocols. Nurses, allied health professionals (physiotherapists and occupational therapists) and healthcare assistants wore clean and well maintained uniforms. They were adhering to the rules around minimal jewellery, short and clean nails, and being bare below the elbow. Doctors and staff not in uniform (such as pharmacists) adhered to trust policy in the same way. Volunteers also had short-sleeved polo shirts provided by the trust and we observed them adhering to infection control protocols when entering patient areas. All the staff we observed washed their hands and used hand gel as required. Visitors were encouraged to do the same. We saw staff wearing personal protective equipment (aprons and gloves) when required. There was sufficient stock of personal protective equipment and hand-wash sinks, soap, paper towels and hand gel in clearly visible areas.
- Patients recognised good cleaning. The hospital trust had scored well in cleanliness in the patient-led assessments of the care environment (PLACE) surveys in 2013 and 2014. In 2014 the trust improved to score 96 (from 95 in 2013) which was the same as the NHS England average.
- Clinical waste was mostly well managed. Single-use items of equipment were disposed of appropriately, either in clinical waste bins or sharp-instrument containers. The vast majority of the waste bins or containers we saw on the wards or within the theatre units were unacceptably full. Nursing staff said they were emptied or removed and replaced regularly. There was, however, one sharp-instrument container on the day surgery unit when we visited for our Sunday

# Surgery

unannounced inspection which was overfull. The lid was not closed and there were syringes on the top which could be easily removed. The unit was not in operation at the time.

## Environment and equipment

- There was safe provision of resuscitation equipment, although one trolley we checked was not properly closed. Trolleys and equipment including defibrillators on each ward and in the units were checked daily, with records showing completion. The trolleys were a standard type, constructed from metal and red in colour. They were well placed within wards and units so they stood out and were easily accessible. With the exception of one, resuscitation trolleys were locked with a breakable seal and, of those we checked, this number was recorded as part of the checking routine. This demonstrated the trolley had not been opened or equipment used or tampered with since it was last used. There was a trolley in the day surgery unit which we checked on our unannounced visit in which, although had a seal, the drawers were not properly closed and the medicines and fluids were accessible. As with all the issues we have reported on connected with the unlocked day surgery unit, the hospital trust took urgent action and rectified this situation. We received a full and satisfactory report of the remedial action taken.
- Theatres and recovery rooms were supplied and fitted with the appropriate equipment. Recovery areas had oxygen and suction at each bed space. The unit was equipped with echocardiograms (ultrasound heart scanners), non-invasive ventilators, pulse oximeters, and equipment for the monitoring of the concentration or partial pressure of carbon dioxide in respiratory gases (capnography). Each bed space had emergency call systems which were tested regularly.
- Almost all medical equipment in theatres had been serviced and maintained as required. We reviewed the servicing dates for equipment including operating tables, anaesthetic machines, infusion pumps, oximeters, warming units, and bone freezers. The exception to this was one of the equipment servicing lists reporting six electrosurgical units (four in theatres and two in the cardiac catheter suite) not having been serviced by their due date varying from March to July 2015. The defibrillators throughout the hospital, so including the wards, were all also within their servicing dates.
- There were three beds without piped oxygen or vacuum suction provision due to increasing beds on Meldon ward. These three beds were added now almost permanently to three of the four-bed bays on Meldon ward to make them five-bed bays. The wards did, however, have portable oxygen and suction on the resuscitation trolleys. Staff told us patients who were at any increased risk, or anticipated or required to have either of these services, were not placed in these areas. The patients we reviewed on our unannounced visit had been risk-assessed and one patient who had given cause for concern was going to be moved to a bed with full provision.
- In the areas we checked, all consumables and equipment were within their expiry date. The nursing sisters we talked with said the stocks, stores and trolleys were regularly checked by one of the nursing or healthcare team, or the theatre stock team in the operating theatres. Staff checked for evidence of damage to packaging (damaged items were then disposed of) and for items approaching or past their expiry date. Staff said they endeavoured to use equipment first when it was approaching the use-by date. We observed consumables and equipment in the departments were kept to a minimum of those things used often in order to reduce waste and the risk of expired equipment.
- Equipment was mostly stored safely. Flammable products were in locked steel cabinets. This was observed in critical areas such as the operating theatres and the decontamination and sterilisation unit. There were some chlorine tablets left on the side in an unlocked ward sluice and these were removed when we highlighted this and put away safely by staff. Store rooms in theatre were fitted with an alarm which would activate if the door was not closed properly and could only be silenced when the door was properly closed.
- With the day surgery unit unoccupied and unlocked on our unannounced visit, the equipment in this area was placed at risk.

# Surgery

- Almost all areas of the hospital we visited were secure with the exception of the day surgery unit on the unannounced visit. Staff had close-proximity cards to give them access to areas not open to the public. Some wards were secure and visitors were required to announce themselves before entering the area. People coming to the operating theatres who did not have direct access were met by a ward clerk who, as they did with us, checked people's identity and asked them to wait to be escorted any further into the unit.
- The call bell response was observed as acceptable. There were, however, problems with hearing call bells in the surgical assessment unit (SAU). The call bell timely response rate in the SAU was 71% on our visit – which was comparably poor. However, the nurses were often unable to hear the call bells as the panel where they buzzed was in another part of the department. We observed they could not be heard from some parts of the unit.

## Medicines

- Most medicines were supplied and stored securely on the wards, theatres and departments. There were some fluids on the wards in unlocked cupboards. When this was brought to the attention of the nurse in charge this was rectified. When we visited the day surgery unit on our Sunday unannounced inspection there were two almost empty bottles of liquid medicines left on the side. One was liquid morphine and the other was a paediatric anti-inflammatory/analgesic liquid medicine. Both had some dregs remaining in the bottle. There was a closed bag on the side of the nurses' station for return to pharmacy which contained medicines. The unit was not receiving patients at the time, but was accessible from the main hospital corridor.
- Most medicines were otherwise in locked cupboards with appropriate staff being responsible for the keys. There were arrangements for the supply of regular medicines. An inpatient pharmacy service supplied stock drugs to all wards and departments and dispensed discharge medicines for patients to take home. There was an emergency medicine stock which all staff we asked knew about and how to access it out of hours. Medicines' refrigerators were available with temperatures recorded daily to show medicines requiring refrigeration had been stored at a safe temperature.
- The hospital was not meeting targets to complete medicine reconciliation for new patients. The National Institute for Health and Care Excellence (NICE) guidance recommended all patients had their medicines reconciled within 24 hours of a change of care setting. The hospital policy required 80% of patients to have had their medicines reconciled within 24 hours. The September 2015 results showed 45% complete in 24 hours and 67% complete overall. April was 48%, May 45% and June 45% of reconciliations completed in 24 hours. Some staff told us the reconciliation process was often completed when the medicines for the patient to take out were screened. This was often one of the reasons for medicines for patients to take home being delayed.
- The ordering, receipt, storage, administration and disposal of controlled drugs were in accordance with the Misuse of Drugs Act 1971 and its associated regulations. We checked a number of stocks and the registers and found them to be accurate. There were manageable levels of stocks to prevent medicines going out of date and the risk of errors.
- We had a concern with the handling of a liquid controlled drug on one ward as this did not follow policy. There were standard operating procedures for controlled drugs to help ensure these medicines were looked after safely and any problems would be identified. We chose to check the controlled drugs on the Trauma ward as we were concerned about how liquids were being checked each day. After a discussion, it transpired staff were measuring the liquid medicines each day by pouring the contents into a container. The liquid was then measured with a syringe before returning it to the bottle. This was not following trust policy on liquid medicines (where a visual estimate was sufficient) and would have inevitably wasted small increments of the medicine each time, and brought potential cross-contamination risks.
- The relatively recently implemented electronic medicine management system was being used well, although the system was not able to provide a record for all medicines and there were other paper-based systems running alongside. The surgery wards were using the electronic system for patient medicines, but required a supplementary paper chart for certain items such as patient controlled analgesia, oxygen, venous

# Surgery

thromboembolism stockings in use, and variable-dosing antibiotics. There was also an infusion pump paper record still being used in the day surgery unit. There were different views from staff as to whether this record was still approved for use. Within this record there was no area to note if the patient had any notable allergies.

- There were some issues with the electronic system and staff were finding ways to work around them. These were recognised and solutions being sought. There were also a number of ways in which information could be entered to the system which held some risks for inconsistent practice. Staff had a clinical risk log to use to register any concerns they had with the system to be examined centrally. Those we saw entered to the clinical risk log had all been responded to by the team managing the new system implementation.
- There was some inconsistent recording of patient allergies in patient records. In some supplementary charts we looked at there were blank boxes where it had not been recorded. There were two patients on Ampney ward where antibiotics had been prescribed on the supplementary charts but there was no record of any allergy or intolerance. In a patient's records on the overnight area in the day surgery unit a GP letter had informed the hospital of the patient's adverse reaction to aspirin and another heart medicine. However, on the drug chart and one of the surgery proforma documents, 'NKDA' (no known drug allergies) was written.
- There was a highly regarded efficient pharmacist service for elective surgery patients admitted through the theatre admission lounge. The theatre admission lounge worked with a prescribing pharmacist on the staff. Patients therefore had their medicines prescribed in advance onto the electronic prescribing system when the patient was admitted and prior to their surgery.

## Records

- There was a serious breach of patient-record security at the hospital. On our unannounced visit to the hospital on a Sunday we were able to easily enter the unoccupied day surgery unit on the first floor. There were patients in the waiting area for the day services unit who were waiting for endoscopy services. This waiting area was at the entrance to the day surgery unit area. When we entered the separate and unlocked waiting area for day surgery, we found patient pre-operative notes with names and addresses and

procedure notes in two unlocked filing cabinets. There was a complete set of patient records on the base of a notes trolley in the adjacent unlocked day surgery ward area. There was a cardboard box of confidential waste on the floor below a desk where there were confidential patient records. This included discharge notes, numerous theatre operating lists, prescription charts, patient notes, handover notes, and controlled drug prescriptions. All of these contained confidential patient information. As with all the issues we have reported on connected with the unlocked day surgery unit, the hospital trust took urgent action and rectified this situation. We received a full and satisfactory report of the remedial action taken.

- On the wards and units, there was otherwise mostly good attention to patient record safety and confidentiality. Patient records on wards were held securely either in staff-only rooms or in locked trolleys. There were some patient notes in a container outside a patient's room on the Trauma ward which were open to be tampered with, removed or read by unauthorised people. The matron recognised this possible breach of confidentiality and the notes were removed to the patient's room for better security. Nursing notes were kept at patients' bedsides which did not provide them with complete confidentiality, but they were readily available and mostly supervised by the nursing staff.
- Patient records were of variable quality and ease of use. There was a new paper-based patient care plan with 44 pages to be completed (dependent on what care plans were required). This had recently replaced the electronic patient record system. Those we reviewed had been relatively well completed and were comprehensive. But we recognised these documents were time consuming to complete for staff with competing priorities. For example, on the Trauma ward on our unannounced inspection we reviewed the notes for a patient who was living with dementia and about whom concerns had been raised by another patient. We were told the patient had not been eating or drinking well. There were care plans for eating and drinking but the records showing the actual information was in another supplementary document. The record for meals showed ticks on some meals on some days, but otherwise question marks in the gaps. It was not clear therefore what the patient had or had not eaten. As the information was both unclear and incomplete there had been no adjustment to the

# Surgery

care plan. Staff had, however, requested the doctor to review the patient, although this had not yet been recorded. The same patient had suffered an unwitnessed fall on the previous night. There was an updated care plan produced for the patient following the fall, and the incident had been reported.

- Records were mostly in good physical condition with some kept in better condition than others. The set of notes we found left in the closed day surgery unit were, however, in poor condition. Many of the pages were loose and the folder holding them together was falling apart.
- In patient notes, resuscitation decisions were considered and well documented. The hospital had recently introduced the use of the new Treatment Escalation Plan and Resuscitation Decision Record to replace the previous Do Not Attempt Cardiopulmonary Resuscitation forms. The Treatment Escalation Plan forms we saw were easier to follow and contained more detailed and useful information. There was a clear and comprehensive guide to assessing a patient's mental capacity to make their own decisions and what to do in the event this was not the case. This included when it was appropriate to use an Independent Mental Capacity Advocate (IMCA) if a decision needed to be taken in the best interests of a patient without capacity to take their own. We saw well completed forms and documentation of discussions with the patient and/or carers about the limitations of treatment and risks associated with the possible options.

## Safeguarding

- Most staff were up-to-date with their training to recognise and respond in order to safeguard a vulnerable person. The training compliance with safeguarding vulnerable adults as at August 2015 showed 91% of staff were compliant with the training. In the three courses for child protection, 92% had completed level one, but only 71% and 65% respectively had completed levels two and three against the trust target of 90% (although the safeguarding policy stated a 95% compliance).
- There were policies, systems and processes for reporting and recording abuse. The safeguarding adults at risk policy had been implemented in September 2013 and was now due for review. The policy did not yet

mention the Care Act (2014) which had superseded the government's 'No Secrets' paper of 2000. The policy did, however, reference the local authorities' joint multi-agency policy to ensure approved and recognised local safeguarding systems and processes were adhered to. The policy listed definitions and types of abuse and who might be at risk. It was linked with the provisions of the Mental Capacity Act (2005) in relation to deciding if a person was vulnerable due to their lack of mental capacity to make their own decisions. The policies (including the policy for child safeguarding) clearly described the responsibilities for staff in reporting concerns for both adults and children, whom, as required, were subject to different procedures. There were checklists and flowcharts for staff to follow to ensure relevant information was captured and the appropriate people informed.

- Staff we spoke with were clear about reporting safeguarding. They understood their responsibilities and the trust's processes for reporting any suspected abuse. Examples of reports made by staff included notifying the local authority when patients came into the hospital with evidence of abuse or neglect. If a patient came from a care home in the community with a pressure ulcer, for example, this would be reported to the relevant local authority.

## Mandatory training

- Mandatory update training was not meeting trust targets. Staff were trained and updated in a wide range of statutory and mandatory subjects at various intervals, but the directorate in which surgery services sat (planned care) was not meeting trust target levels overall for updating training. The training included a wide range of topics such as dementia awareness, the Mental Health Act, life support, and health and safety topics. Compliance with the mandatory training requirements at the end of August 2015, against a trust target of 80%, showed staff at 77%. None of the wards, day surgery or the surgical assessment unit had achieved targets (they were between 65% and 75%). The theatre staff (recovery, scrub teams, theatre stock team, HSDU) had met their 80% targets, along with the trauma coordinator service.
- In terms of subject matter, there was good compliance with update training in the Mental Capacity Act, dementia awareness, medicines management, and

# Surgery

venous thromboembolism, for example. Those subjects where compliance was low were in some of the more specialist mandatory training. For example, only 5% of staff required to do so had completed their intra-aortic balloon pump training and records showed no staff had completed their competency assessment. In other statutory subjects, 67% of staff had completed their update training in consent, mental capacity and Deprivation of Liberty, and 70% had completed infection prevention and control.

## Assessing and responding to patient risk

- Surgical patients admitted to the day surgery unit for overnight care were assessed for their suitability to minimise the risks of staying in a unit not designed for overnight stays. There was a protocol which was expected to be reviewed each morning (and approved by the matron) to ensure patients on the unit met the criteria. The criteria included patients being medically stable; having no complex mental health needs (such as living with dementia); being independently mobile; meeting the same-sex criteria for the unit at the time. It should be noted these criteria did not entirely match those in the hospital capacity management policy. These characteristics were audited and the form signed by the matron with any patients no longer meeting the criteria being raised through the hospital bed meeting to be moved. The capacity management plan and the day surgery unit criteria for admitting patients mentioned a patient should not stay for more than 24 hours. If this was needed the patient would be admitted to a ward. However, one patient we met had been on the ward for 72 hours.
- Records we saw showed not all patients admitted in an emergency had been seen by a consultant within the recommended 12 hours. We reviewed 10 sets of notes to look for this specifically and eight of those did not record the consultant review.
- The hospital had a policy for monitoring acutely ill patients, although this was not being audited for effectiveness. The hospital had implemented and was using the recognised 2012 National Early Warning Score (NEWS) system for the monitoring of adult patients on wards. This used a system of raising alerts through numerical scoring of patient observations. The system was used on wards and also in recovery rooms. We looked at 24 sets of patients notes in six wards/units. We

saw the NEWS forms completed and in use appropriately in the patient records we reviewed, with the exception of one which had not been accurately completed. The hospital had yet to run a snapshot audit of the NEWS scores in order to determine if they were being used effectively.

- The hospital had a rapid response team (called the MET Team: Medical Emergency Team) and critical care Outreach team to respond to emergencies around the clock. The MET team had specialists in resuscitation and emergency care. The Outreach team was staffed by trained critical care nurses, but did not provide cover 24 hours a day, as was recommended by the Faculty of Intensive Care Medicine Core Standards.
- Patients were assessed pre-operatively. The nurse-led team in the pre-operative assessment unit (Cherwell) assessed day surgery patients and most surgery inpatients. Patients were assessed for their general health and any medicine or other potential complication needing to be considered before surgery could take place. Anaesthetists also provided patient assessment and consultation through the pre-operative clinics

## Nursing staffing

- Nursing staffing levels were leading to patients not being provided with quality and safe care at all times. There were high levels of vacancies in the nursing staffing. In data we were provided (for June 2015) vacancy rates were 14% on Ampney and Aldbourne wards. In Meldons ward, the recovery units, and the surgical assessment unit, nursing vacancies were running at 8% to 9%. On the trauma ward and in the anaesthetics team were vacancies of 12%. In oral surgery, the nursing vacancy rate was 13%.
- The sickness levels within nursing in surgery services were above the NHS national average of around 4%. Data we were provided with only went to May 2015, but during the six months to May 2015, rates of sickness in the four surgery wards and the Shalbourne Suite were around 5% on average. There had been high rates of sickness in the day surgery unit with 19% in January 2015, but by May this had resolved to just 2%. There were sickness levels in the anaesthetics nursing team and oral surgery nursing in May 2015 of around 8%.

# Surgery

- There was a high use of bank/agency staff used to cover unfilled shifts left by staff vacancies, planned leave or sickness. In the staffing data supplied for April to September 2015, 19% of shifts had been covered in this way on Ampney ward. The surgical assessment unit and Trauma ward had covered 12.6% of shifts with bank/agency staff. The Shalbourne Suite had used 15.6% of bank/agency nurses (mostly bank).
  - Not all vacant shifts were covered to provide a full cohort of nursing staff. There were high numbers of shifts not filled by bank or agency staff – although it should be noted we were told these would have been requested, but no staff were available, or the staff did not turn up. For example, in the period from April to September 2015, 7.1% of shifts were not covered on the day surgery unit. On Ampney and Meldon ward, just over 5% of shifts were not covered. The surgical assessment unit was down on 6.3% of shifts and the Trauma ward by 5.5%. There were some incident reports completed, but these were infrequent.
  - The wards were not using proactive acuity tools to determine and adjust staffing levels. Staffing levels were set and fixed by workforce planning. Staffing levels had not been adjusted on Meldon ward, although the ward was now caring for an additional three patients, which was an increase of just below 10%. Staff told us how the acuity or needs of patients were not taken into account in fixed staffing levels. For example, there were 28 patients on the Trauma ward, which was a ratio of one nurse to seven patients in daytime (one to just over nine at night). One of these nurses was also managing the ward, but this role was not supernumerary. This was managed by three of the nurses caring for eight patients, and the ward manager caring for four patients. To accompany the nurses in the morning were three healthcare assistants (called nursing assistants at this trust) and two in the afternoon and evening. On both our announced and Sunday unannounced visit, all of the patients on the Trauma ward were assessed as at risk to falls. There were 22 patients, many confused, who needed support from two members of staff for washing, showering, mobilising, and using the toilet. Staff on wards and units we visited described how staffing problems impacted on patients. This included:
    - Not being able to provide anything other than basic care. Patients often not provided with anything more than a basic wash. There were some patients who had not had their hair washed for two weeks. Not able to spend time with patients to find out more about them.
    - Patients not being mobilised and this leading to slower rehabilitation, reduced independence and confidence.
    - A patient had wet the bed as they had waited 10 to 15 minutes from asking for a bed pan. They were then placed onto a bed pan for 20 to 25 minutes. In the meantime the patient's family arrived and found the patient in a wet bed and made a complaint to nursing staff.
    - A comment card given to us by a relative of a patient said they had witnessed a patient "left in a wet bed for about three hours, eventually moved into a chair, but the bed was never changed and later found to be dry so [the patient] was put back into bed as it was."
    - Staff said call bells being cancelled (that is silenced) and the patient was asked to wait a few moments as the statistics were being measured and pressure on staff was already high.
    - Drug rounds being interrupted to help with patient care. Medicines were often given late.
    - Staff were worried about making mistakes with long shifts and extra hours worked.
    - With so many confused patients, meals sometimes went cold when there was no one to help or staff needing help elsewhere.
    - Staff missing their training and appraisals and opportunities for professional development.
    - Criticisms from the community for poor discharge paperwork. Errors with discharge such as missing equipment for the patient to take home and arrangements for ongoing catheter care.
    - If staff were brought in to provide support from the intensive care unit, they were not able to administer medicines as they were not trained to use the electronic prescribing system.
- Other issues with staffing included:
- Supervisory nurses on wards were required to care directly for patients when there were not enough staff.
  - There was a lack of administration staff on the wards which was adding to the workloads of senior nurses.
  - Nursing staff said the hospital attitude to relaxed visiting hours was helping with some aspects of patient care

# Surgery

and safety. Families were able to visit anytime from 8am to 8pm and encouraged to help with meals, encouraging fluid intake, and supporting particularly confused patients. This also helped with communication with the medical staff who, rather than the nurses, would be more available when visitors came to answer questions and give advice.

- Nursing staff told us they sometimes felt vulnerable when moving to different wards or caring for patients who were not in their usual experience. Staff said they were sometimes moved to other wards when those were short-staffed, or patients were being nursed in areas not designed for this purpose. Staff on the day surgery said this was something they felt affected them often. Staff who normally worked with patients who were coming for day surgery were now also caring for patients who were being accommodated on the unit overnight. Staff said although they had strong support from an experienced sister, they were concerned they would be faced with complications in a patient they did not necessarily recognise. They said they felt vulnerable to missing something. When we asked if staff had any examples of this having impacted on patients in the past, they said it was more of a risk and it would only be addressed if something went wrong.
- There were safe handovers. We observed a number of excellent handovers from senior sisters going off and coming on duty. They were knowledgeable about their patients, their risks, possible plans for discharge, and any new information.

## Medical staffing

- The hospital trust had a medical staffing skill mix which was similar to the England average. Around 40% of medical staff were consultant grade (England average 41%) and around the same level as the England average were foundation year trainees. There was an acknowledged vacancy rate for registrar doctors in the trauma and orthopaedics speciality which had been included in the trust risk register. Three new doctors had been recruited at the time of our inspection. There were other vacancies the trust had advertised in the ophthalmic, orthodontic, and ear, nose and throat specialties. The trust had arranged for ophthalmic patients to be treated by another provider to reduce the waiting list, which it had done successfully. The referral to treatment times were meeting the 18-week referral to

treatment waiting time targets for this specialty. The orthodontic service was, however, raised on the risk register due to medical staff shortages and the hospital had currently stopped taking new referrals.

- Nursing staff we met said they felt well supported by the medical teams. Although some of the wards did not have doctors based there, they usually came quickly when requested and did spend most of their time on the wards. When we visited the hospital on both the announced and unannounced visits we observed doctors reviewing patients and coming onto wards when requested by nursing staff. We met a patient who wanted to self-discharge from one ward and the duty doctor came to the ward quickly to talk to them about their decision. We then saw the same doctor attending the surgical assessment unit to review a new admission shortly afterwards.
- Use of locum doctors was reported by the trust to be relatively low in the surgery division. However, minutes from the planned care division (in which surgery sat) were contradictory in relation to anaesthetists. The trust reported there had been some locum doctors employed in general surgery and anaesthetics earlier in the year but this was relatively low. The meeting minutes reported a high usage of locums in the anaesthetics team. Staff told us the medical teams were flexible and adaptable and provided a safe level of cover.
- Consultants and doctors carried out appropriate ward rounds most of the time, although some of the wards and patients reported a variable practice at times. Staff on the surgical assessment unit said the ward round did not always take place as planned at 8am. The evening ward round was also described as “not regular.” A patient we met at 4pm who had been admitted as an inpatient on the day surgery unit had been waiting to see a doctor about going home since 10am. A patient we met on the Shalbourne Suite had also not seen a doctor by 4pm, despite being told they would during morning rounds.

## Major incident awareness and training

- The trust had a current major incident plan produced in 2014. Staff knew how to access and distribute the policy and in what circumstances it was relevant. The plan was, for example, immediately to hand in the recovery area in theatres. There were plans for the individual

# Surgery

critical departments in the event of a major incident. This included the surgical assessment unit, day surgery unit, theatres and the sterilisation and decontamination unit (HSDU). Although there were action cards for each of these areas, there were no actions for the wards, even though the surgical wards were included as receiving wards. There were no instructions for ward managers to follow to, for example, commence urgent discharge of patients, ensure stocks were adequate, and prepare staff.

## Are surgery services effective?

Good



We have judged the effectiveness of surgery services as good, although some areas required improvement.

Length of stay in the hospital was good, being below (better than) the England average. Patients' pain was well managed with specialist input. Nutrition and hydration was mostly well supported. The hospital performed better than the England average in the national hip fracture performance audit, but performance had declined from the previous year. The hospital performed well in the national lung and bowel cancer audits in 2014. Post-surgery readmission rates were generally good, although this varied between planned and emergency surgery. The hospital performed well in the patients' review of the outcomes following hernia and hip/knee replacement and varicose vein surgery.

Not all staff had been given their annual appraisal and this was not meeting trust targets. There was, however, a good standard of competence among the staff teams. There was good multidisciplinary working with a common sense of purpose among staff. Important services were provided seven days a week and there were no problems with getting access to information.

### Evidence-based care and treatment

- Despite delays in discharges, predominantly for patients needing social care packages or continuing healthcare, the length of stay (LOS) for surgical patients within the hospital was mostly below (better than) the England average. It is recognised as sub-optimal for patients to remain in hospital for longer than necessary and a barrier to other patients being admitted. The latest data produced for the trust by the Health and Social Care Information Centre covered 2014. For all elective surgery the LOS was 2.8 days (England average 3.1 days) and for emergency surgery 4.2 days (England average 5.2 days). Within elective surgery there were, nevertheless, longer stays than average in trauma and orthopaedic surgery (3.7 against 3.1 days) and general surgery (3.6 against 3.1 days), but these were mitigated by much shorter LOS in urology surgery (1.5 against 2.1 days).
- In emergency surgery the top two specialities of general surgery and trauma and orthopaedic were below the England LOS average and ear, nose and throat surgery had the same LOS. Notably, trauma and orthopaedic patients' LOS for emergency surgery patients was 6.3 days against the England average of 8.5 days.
- The hospital reported a high level of compliance with patient assessment for venous thromboembolism (VTE), but there was evidence this was not measuring anything meaningful. The origin of the audit was the electronic medicine prescribing system. We were informed the system did not allow a patient to be progressed to prescription of medicines without a VTE assessment being carried out. However, when this was examined further, there was a section to complete at the beginning of a record to indicate if a patient was a medical or surgical patient. Once this box was checked, it was then possible to prescribe medicines without needing to complete a VTE assessment. A patient record we reviewed to test this on Meldon ward showed VTE as being 'complete' but only the surgical box had been checked and the assessment had not been completed. When we asked senior directorate management about this they were not able to confirm what the otherwise highly successful audit was measuring.
- Patients were assessed for risks of venous thromboembolism prior to surgery, in line with the National Institute of Health and Care Excellence (NICE) guidance. Pneumatic compression boots were used in theatre where required to reduce the risk to patients of venous thromboembolisms (VTE or blood clots). There was evidence in patient records of the use of prophylaxis (proactive prevention) for VTE.
- Patients were treated without discrimination through the use of staff mandatory training and policies assessed and approved for equality and diversity. This included no barriers to patients on grounds of age,

# Surgery

disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief, and sexual orientation. From talking with staff and hearing about the patients who had been admitted to the hospital, there was no evidence of any discrimination on any of the above grounds. The lack of any discrimination extended to any visitors to the unit, who were given full access rights while required also to act in the best interests of the patient. Staff spoke about respecting people's wishes, rights and beliefs. They were able to describe a wide range of different needs and talked about patients' individuality and right to be different.

## Pain relief

- Pain relief on wards was well managed. Patients prescribed pain relief to be given 'when required' were able to request this when they needed it. Patients told us they were asked by staff if they were in any pain and medicines were provided in line with the patients' prescriptions. Nursing staff said, and we observed, patients were regularly checked for pain.
- Pain was managed well for patients unable to always express themselves. The hospital was using the recognised Abbey Pain Assessment Scale tool. This tool was specifically helpful for patients with cognitive impairment who may not be able to express how they felt. It involved checking if a patient was showing signs of pain from facial expressions, if they cried out, whether they were anxious or withdrawn, and physiological symptoms such as a temperature or pulse outside of normal limits. These areas were scored and actions taken if the tool showed any evidence the patient was in pain.
- There was a hospital pain team providing specialist input into pain management. This included a consultant in pain management and a team of four specialist nurses. Staff were aware of how and when to contact the team for advice and guidance.

## Nutrition and hydration

- Appropriate guidance and protocols were produced and followed to ensure patients had the right levels of hydration. All patients' had their hydration levels monitored on a daily basis to ensure they were receiving a good fluid balance. Around three years ago the trust had undertaken an education and training programme for staff, patients and carers about the need for good

hydration. Those nursing staff we met thought this was now well embedded in daily nursing care. A number of patients said staff had encouraged them to drink and explained why this was essential for their recovery. Staff also told us how a poor or deteriorating fluid balance was often an early indicator of possible problems to investigate. For patients able to take their own fluids, drinks were available on bedside tables and within reach.

- The Malnutrition Universal Screening Tool (MUST) was used to monitor patients who were at risk of malnutrition. The tool (an accredited screening tool) screens patients from risks of malnutrition but also for obesity. Where patients were identified as at risk nutritional care plans were developed to encourage intake, a food chart was commenced, and there was involvement from a dietician. In the 13 sets of care records we reviewed from the wards we visited, assessment of nutritional risk had been completed in 11.
- Patients were fasted appropriately pre-operatively when admitted as inpatients prior to their surgery; although not unlike most acute hospitals there were no tailored regimes. Therefore all patients were given the same instructions irrespective of their place in the operating list. Patients who came for day-case procedures were given appropriate instructions about food and drink intake before their procedure. If a patient was operated on in an emergency situation, their response to the risk of nausea and vomiting was managed in theatre and recovery either with appropriate medicines or close monitoring.
- There was provision for patients who needed extra help to maintain their nutritional intake. There were nutritionally enhanced soups and drinks available along with soft diets for patients who had difficulty with swallowing. Patients who had difficulty with eating or drinking were assisted by staff. We observed a lunch time on one of the wards we visited on our Sunday unannounced visit. There were a high number of patients who needed support and encouragement to eat their lunch. They were supported by healthcare assistants and a volunteer working on the ward. It was difficult for the staff, despite it being 'all hands on deck' to help everyone in a timely manner, and all the food was dished up at much the same time. It was inevitable

# Surgery

some of the food would not have therefore been hot when some patients were helped and encouraged to eat. The nursing staff said this was inevitable and a regular problem on wards with frail or confused patients.

## Patient outcomes

- The hospital performed well in the Patient Reported Outcome Measures (PROMs). These were patients who reported back to the hospital on their outcome following surgery for groin hernias, hip replacements, knee replacements, and varicose veins. With the four procedures, and as with the England average, almost all patients reported their health had improved when measured against a combination of five key general health-related indicators. Almost all patients having hip and knee replacements reported improvements in their outcomes when asked more specific questions (Oxford scores) about their condition. The hospital exceeded the England average for patient improvements in their health for both groin hernia and varicose vein surgery and was much the same as what was a very good national average for improvements in health following hip and knee replacement surgery.
- Hip fracture performance was better than the England average in most audit measures. However, although the hospital had improved in two of the seven areas of performance in the Department of Health standards for fractured hip surgery in 2014/15 compared with 2013/14, performance had declined in the others. It remained, however, better than the England average for five of the seven measures. In 2014/15, 41% of patients had been admitted to orthopaedic care within four hours, which had declined from 75% in the previous year, and was below the England average of 48%. The length of stay for patients had also increased from 19 to 20 days, and this was just above (worse than) the England average of 19 days.
- In two other measures, namely surgery on the day of admission, and pre-operative assessment by a geriatrician, the hospital performance had declined over the previous year, but was still better than the England average. Patients developing pressure ulcers had improved from 4.5% to just 1.6% (England average 3%) and the provision of a bone-health medication assessment had improved from 69% to 99.5%. Almost all patients had a falls assessment in both 2013/14 and 2014/15.
- The trust performed well in national cancer audits. In the lung cancer audit, the trust was better than the England average for discussing patients at a multidisciplinary level, and patients receiving an appropriate scan. In the bowel cancer audit, the trust was better than the England average for discussing patients at a multidisciplinary level, being seen by a clinical nurse specialist, and receiving a relevant scan. The hospital was also credited for having well-completed data in the bowel cancer audit.
- The hospital did not comply with 18 out of the 28 measures for the first National Emergency Laparotomy Audit (NELA) 2014. This included pathways for the management of patients with sepsis and for the enhanced recovery of emergency general surgery patients. A number of the other areas of non-compliance have since been addressed. This includes implementing a formal rota for round-the-clock endoscopy and interventional radiology.
- In the first NELA patient report 2015, the hospital achieved the 70% to be compliant with recommendations in just two of the ten standards. The hospital achieved between 50% and 69% compliance in six of the others, and less than 50% compliance in the remaining two. Compliant standards were those for a consultant surgeon and anaesthetist to be present in theatre. Those standards failed (achieved for less than 50% of patients) were for:
  - Patients to be reviewed by a consultant surgeon in under 12 hours from the emergency admission.
  - Patients over 70 years of age to be reviewed by a specialist in medicine for care of the older person.
- The hospital was actively involved with the Emergency Laparotomy Collaborative: a three-region project aimed at improving emergency laparotomy management. The hospital (one of only four chosen in the South of England) was being funded to trial an elderly care review of emergency laparotomy patients.

# Surgery

- Patient readmission rates after surgery (due to corrective measures needed or infections) were variable between elective (planned) and emergency surgery. When reviewing the data for the top three surgical specialties from December 2013 to February 2015 (in relation to how many procedures were performed) there were 3% less patient readmissions overall for elective surgery than the England average, but 8% more than average for emergency surgery.
- In elective procedures, urology surgery followed by general surgery performed best against the England average for patient readmissions, with trauma and orthopaedic surgery performing less well with 16% more readmissions.
- In emergency procedures, trauma and orthopaedic surgery had slightly fewer patients readmitted than the England average (2%), but there were more for both general (11%), and ear, nose and throat surgery (17%).

## Competent staff

- The directorate including surgery (planned care), was not meeting the trust target for 90% of staff to have had their annual review. Some departments did well while others were falling behind. Overall, 66% of staff had a review in the 12 months to the end of August 2015. If you removed the members of staff in 'planned care' who worked in other areas reported elsewhere in this report (such as community dental staff and some of the outpatient services) the number reduced slightly to 65% of staff. The only department with 100% was the theatre stock team where all four staff had received their annual review. On the wards, two of the four wards (Ampney and Meldon) were almost at 90% and the other two (Aldbourn and the Trauma ward) were 43% and 68% respectively. The 25 Shalbourne Suite ward staff had achieved 48% (of 12 staff). Of the departments with high numbers of staff, the 58-strong elective scrub team had just 36% of staff appraised, but the elective orthopaedic scrub team of 44 staff had achieved 86%. Fewer than 50% of the 30 staff on the surgical assessment unit had their annual performance reviewed.
- All staff we asked knew who was responsible for their appraisal. Staff in lead roles knew who was in their team and due an appraisal from records available in the electronic staff record system. The staff we met in lead

roles knew how many appraisals were outstanding. We were told some had to be postponed due to staff being required to work on another ward or cover absence or vacancies on their own ward.

- The majority of staff were evaluated for their competence. The hospital followed the guidelines for the ward or unit where staff were based. Competence in recovery, for example, followed the guidelines of the Royal College of Anaesthetists for theatre staff. Staff were evaluated by members of staff who were approved by the trust's Academy. Competency measures were assessed, issued and approved also by the Academy. New staff were required to work a period of supernumerary time on wards and required to complete competency tests before building up their skill base. Agency nursing staff coming onto wards were required to be competent with the use of the electronic prescribing system before they would be approved to work at the hospital. Agency staff were provided with a verbal induction, but on the two wards we asked there was no checklist or other document in use for agency staff and their supervisor to sign to show they had been inducted.
- Medical staff were evaluated for their competence, although this group were not meeting the trust target of 90%. The doctors we met said the 'revalidation' programme was well underway. This was a recent initiative of the General Medical Council, where all UK licenced doctors are required to demonstrate they are up to date and fit to practise. This is tested by doctors participating in a robust annual appraisal leading to revalidation by the GMC every five years. Appraisals of medical staff were carried out each year. Of the 117 medical staff listed in the planned care directorate, 65% had received their annual appraisal in the year to the end of August 2015.

## Multidisciplinary working

- There was cohesive collaborative working from staff contributing to patient care. We observed a common sense of purpose among staff. In day-to-day working staff proactively supported each other. We observed and were told there was no obstructive hierarchical structure and all staff were valued for their input and roles. As required for patient safety, this was particularly strong within the theatre team. There was a significant

# Surgery

improvement in multidisciplinary teamwork in theatre in relation to the use of the World Health Organisation surgical safety checklist. Each member of the team had a recognised important role.

- Patients were receiving physiotherapy to help their recovery. Therapy staff worked closely with the medical and nursing teams to provide a collaborative approach to patient rehabilitation. Staff and patients spoke highly of the physiotherapy care provided to surgery patients. The physiotherapy team worked seven days a week, and were on call when they were not on site.
- There was multidisciplinary input involved with all patient care. The patient records demonstrated input from therapists, including dietitians, speech and language therapists, and occupational therapists, as well as from the pharmacist team, the medical team, and diagnostic and screening services.
- There was evidence of a strong multidisciplinary approach from national cancer audits. In the 2014 bowel cancer audit, there was 99.5% compliance with there being a multidisciplinary discussion in the 219 cases reviewed. This was above the England average of 99.1%. In the 2014 lung cancer audit, there was 96.7% compliance with there being a multidisciplinary discussion in the 151 cases reviewed. This was above the England average of 95.6%.

## Seven-day services

- The hospital trust provided emergency surgery services around the clock. There was a surgery team on site 24 hours a day with support and specialist surgeons on call and able to attend the hospital within 30 minutes. The hospital sterilisation and decontamination services also operated seven days a week. The surgery wards and the surgical assessment unit were open and admitting patients seven days a week around the clock.
- Access to clinical investigation services was available across the whole week. This included X-rays, computerised tomography (CT or CAT) scans, electroencephalography (EEG) tests to look for signs of epilepsy, and echocardiograms (ultrasound heart scans). Endoscopy services were also available across the whole week.

- There were arrangements for the supply of medicines when the hospital pharmacy was closed. A pharmacist was also available on-call out of hours.
- The trauma coordination team were available seven days a week. This team were working with patients, supporting complex orthopaedic discharges to ensure patients left the hospital for safe environments designed to promote their rehabilitation.
- Therapy staff were available in person or on call across the whole week. If therapy staff were off duty, there was access to certain staff out-of-hours through on-call rotas. Otherwise, therapy staff (including occupational therapists, speech and language therapists and dietitians) were on duty on weekdays, and physiotherapists worked seven days a week.

## Access to information

- Access to patients' diagnostic and screening tests was good. The medical teams said results were usually provided quickly and urgent results were given the right priority. Patient records were also said to be available in good time. Records were logged onto an electronic system which would track where they were being held. When we visited the pre-assessment unit (Cherwell) the unit manager demonstrated how the patient records (all held in a locked room with excellent organisation) were registered on the electronic system so staff were able to locate them if required.
- There was varied access and use of the electronic prescribing system due to limitations with the current version (which was subject to upgrades at regular intervals). Some departments within the hospital were not currently using the system in part or in full due to the complexity of medicines. The critical care unit were not yet prescribing electronically so when a patient was discharged from critical care, an electronic record would need to be established. Patient's transferring from critical care had a new prescription chart written when transferred to a surgery ward and the original critical care chart remained part of the patient's permanent medical record. There were limitations with the system, including the possibility to allow prescriptions of the same medicine twice. There were also practical problems with the accessibility of the system which

# Surgery

could be slow to load or quickly lock staff out. These issues had been recently raised along with others by the chief nurse following observation of the drug round on a surgical ward.

- There was good access to intranet-based guidance, policies and protocols. The trust intranet was open and available to all authorised staff. The data within it was locked so it could only be amended, deleted or changed by authorised personnel. There were protocols, policies and guidance for clinical and other patient interventions and care.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients we met said they had been asked to provide valid consent. A patient on Meldon ward and another on the Shalbourne Suite said the consent conversation with the consultant had been clear and straightforward. Both these patients had been through the pre-assessment unit (Cherwell) where they had met the consultant at the end of the day. They said they had been able to ask questions and received clear answers. They said they had been told all the risks and benefits of the procedure and able to discuss what impact the procedure would have on their wellbeing. They had signed consent forms and said all this was checked with them again verbally before they were anaesthetised. Neither of these patients had, however, been given copies of their consent forms. In a number of patient records we looked at on Ampney ward, there was no indication patients had been given copies of these forms.
- Patients were assessed for their capacity to take their own decisions, although there was a record for a mentally frail older patient not including any assessment. This person was reported as having a poor memory and inability to retain information in their medical notes. However, there was no formal assessment of their capacity, although standard 'two-stage test' forms were available. This patient had then gone on to sign their own consent form.
- Patient consent was completed at appropriate times. Consultant orthopaedic surgeons held consenting sessions in the pre-operative assessment centre prior to the patient's procedure. Consent for general surgery was provided by the patient on the day of the surgery.

Consent for emergency surgery was also provided by the patient on the day of surgery if they were able to do so. As with all acute hospitals, some patients had come to the hospital in an emergency and were not able to provide valid consent due to being unconscious or lacking capacity at the time. This surgery was carried out in the patient's best interests and in accordance with the law around life-saving or emergency procedures.

- Most staff had a working knowledge of Deprivation of Liberty Safeguards and when to apply them. The trust had provided training and guidance around what actions would amount to a Deprivation of Liberty and how to proceed to have the deprivation approved. When visiting a mentally frail older patient we observed they were being provided with 'close support' in their best interests, but this was depriving them of their liberty. This had been recognised by staff and acknowledged, but when we went on to review the assessments and request for formal approval, none of the evidence was available.

## Are surgery services caring?

Good



We have judged the caring of the surgery services as good.

Feedback from patients and their families had been positive overall. If there was criticism, this was not around the caring of the nursing staff, but the time they had to provide more than just basic care to keep people safe. The Friends and Family Test produced excellent results. Patients we met in the wards and other units spoke highly of the kindness and caring of all staff. Staff ensured patients experienced compassionate care, and worked hard to promote their dignity and human rights, even though this may have failed at times.

Patients and their family or friends were involved with their care and included in decision making. They were able to ask questions and raise their anxieties and concerns. There was access to chaplaincy services and support from nurses and doctors with specialist knowledge.

## Compassionate care

# Surgery

- Patients spoke overwhelmingly of the kindness of the staff. Patients on Aldbourne ward, the Shalbourne Suite, and staying as inpatients on the day surgery unit all said the same thing of the staff: “they can’t do enough for you.” Most patients we met said the highlight for them was “the staff” and remarked upon their kindness and compassionate care. We observed a confused older patient on the Trauma ward being treated with kindness and empathy by the matron. A patient on the day surgery unit said a nurse had visited the hospital shop in order to buy them and another patient a newspaper to read. Patients we spoke with said they recognised how busy staff were, but all commented upon their kindness and patience. Patients on Meldon ward said they found staff kind and courteous, understanding and encouraging. A patient on Ampney ward said: “the staff are very busy but they are looking after us.”
- We observed mostly good attention from all staff to patient dignity. Any patients we observed in the operating theatres were fully covered in all preparation and recovery rooms, and when returning back to the ward areas. A patient operation we observed demonstrated dignity was maintained at all times, including when repositioning the patient. On wards curtains were drawn around patients, and doors or blinds closed in private or side rooms when necessary.
- One confused patient we met on the Trauma ward was, however, not adequately covered to help preserve their dignity. This was unfortunately observed unintentionally by visitors to the ward. The patient had managed to reverse the hospital gown they were wearing to “help the nurses when I have my shower.” It was 11am and the patient had been waiting for their shower since 8am. Staff immediately attended to the patient when alerted.
- The NHS Friends and Family test results for the five surgery wards showed excellent results. Patients were asked to say if they would recommend the ward to their family and friends. In the six months from January to June 2015, 96% of patients were either ‘extremely likely’ or ‘likely’ to recommend the ward to their family and friends. The test was responded to by an average of 45% of those patients admitted (1,526 patients). The individual ward details for July 2015 (the latest available data) were:
  - Aldbourne ward (elective orthopaedics) would be recommended by an average of 98% of patients (response rate of 29%)
  - Ampney ward (vascular and urology) would be recommended by an average of 94% of patients (response rate of 46%)
  - Meldon ward (general surgery) would be recommended by an average of 95% of patients (response rate of 50%)
  - The Trauma ward (trauma and orthopaedics) would be recommended by an average of 100% of patients (response rate of 22%)
  - Beech ward (mixed female ward with some breast surgery patients) would be recommended by 94% of patients (response rate of 21%)
- We observed and were told patients living with dementia were mostly treated with kindness and understanding. On Aldbourne ward, on our Sunday unannounced inspection, we observed how staff had located a patient who was confused, but also known to appreciate company, close to their nursing station. The patient was able to talk with staff and observe what was going on around them, and appeared comfortable and content. We observed a confused patient who at first wanted to sit nearer the window and then changed their mind a number of times being treated with patience and kindness by the nursing staff on the Trauma ward. One patient commented to us how staff had been “short” with a confused patient, and one nurse had been heard to say: “not her again.”
- The trust scored well in privacy and dignity in the PLACE (patient-led assessments of the care environment) surveys in 2013 and 2014. The results, which were much the same as the England average had improved from a score of 86 in 2013 to 88 in 2014.
- We observed good attention from staff to patient confidentiality. Voices were lowered to endeavour to avoid confidential or private information being overheard as much as possible. Some patients on the wards said, however, they found it was difficult to avoid overhearing some conversations between patients and staff when they took place in the adjacent bed-space. Patient beds were relatively close together on Meldon ward in the bays where extra beds had been added. The space between the beds was particularly poor in the day surgery unit where patients were being admitted to stay overnight.

## Understanding and involvement of patients and those close to them

# Surgery

- Friends and relatives of patients were kept informed and involved with decisions when appropriate. Relatives and close friends of patients we met said they were able to ask questions and could telephone the wards and departments when they were anxious or wanted an update.
- Patients on the day-case unit were given time to ask questions about their procedure and address any anxieties or fears. The nurses demonstrated a level of understanding of their patients' potential to become anxious, even with day-case procedures where the operation was less of a risk or complexity. Staff in the day-case unit gave patients time and made sure they understood any aspects of the procedure and how they would proceed through the unit before going home. Families or carers were able to accompany the patient, or were able to remain in the waiting area or use the café facilities in the hospital.
- There was mostly good communication with patients but there were some examples of where this did not work well enough. For example, a patient we met on a surgical ward had been admitted to the surgical assessment unit and spent eight hours waiting in a chair and on 'nil by mouth' status in order to be ready for surgery. They were then sent home and told to return the following day at 8:30am. They were then waiting all day without being told what was happening. They were eventually operated on the evening of the third day. They were not critical of the care and said the operative and post-operative care was great but communication was poor throughout the pre-operative period.

## Emotional support

- There was access to a multi-faith chaplaincy for patients and their relatives and carers. The chaplaincy team were available in working hours and then on call 24 hours a day all year round. There was a room in the hospital for people to use described on the trust website as "set aside for you to come and be quiet, whatever your philosophy of life, whatever your religion."
- A side room had been identified in the recovery area in theatres which could be used for a patient who was at the end of their life. This enabled the patient's relatives/

loved ones to be admitted to the recovery area to be with the patient. The room was located near an entrance to make visitor access easier and give increased privacy.

- There was support for patients with cancer from a team of Macmillan nurses and the palliative care team based at the hospital. They had a large resource of knowledge and experience to draw upon to provide advice and emotional support. The hospital staff also regularly spoke with experienced staff at a local hospice to get advice and support. Staff were also able to contact and obtain support and advice from social services to further support people where this was needed.

## Are surgery services responsive?

Requires improvement



We have judged the responsiveness of surgery services as requiring improvement, although some aspects were good.

The hospital was using the day surgery unit to accommodate patients overnight, and this area did not meet many patient needs and provide basic facilities. The hospital was not meeting the referral to treatment targets for any surgical specialties with the exception of ophthalmology. The position was not improving. Some waiting times were reducing while others were getting longer. Average waiting times were worse than those in the South of England NHS Commissioning area. There was very high bed occupancy at the hospital and patients were moved around to improve access and flow. The hospital was faced with a high number of patients who were fit for discharge, but without transfer of care packages.

Cancelled operations were below (better than) the England average. There was an excellent pre-operative assessment service, a good theatre admissions lounge and discharge facilities, although these were sometimes crowded with people waiting for medicines and transport.

Most patients enjoyed the food, but were disappointed at the lack of hot drinks outside of mealtimes. Staff supported people with learning disabilities to improve their experience of coming to hospital. Staff were kind and patient with people with dementia, but there were few facilities on the wards, such as easy to read signage and dining areas to help frail confused patients.

# Surgery

Complaints were dealt with, as required, mostly by the Patient Advice and Liaison (PALS) staff team. There was no evidence to suggest this was not being done well and to the satisfaction of the complainants. There was, however, limited evidence to show how complaints were being used to provide learning and produce changes to improve care and patient experience.

## Service planning and delivery to meet the needs of local people

- The hospital was using the day surgery unit (DSU) to accommodate patients overnight when the area was not designed for this purpose. Some of the needs of patients were not being met. At the time of our visit, the eight-bed area in the unit was being used as an escalation ward for surgical patients. Staff told us this was used now almost continually for this purpose. Since 9 April to 9 October 2015 (the last six months), the DSU has been open for 76 days overnight, although infrequently on the weekends (five weekends in six months). If the unit was opened for patients to be admitted, the area would be organised as a single-sex ward. Staff said the other area with trolleys had also been brought into use for overnight stays from time to time for the opposite sex. If this happened, the trolleys were replaced with hospital beds. Data showed there were occasions with more than the eight available beds being used (five days had more than eight beds used, with 11 at most). There were 520 patients accommodated in the DSU over this six month period (although some of that 520 would have been the same patient staying for more than one night).
- There were a number of problems with this arrangement:
  - There was one male and one female toilet for all patients, whether inpatient or day-case. Staff and patients said there were often queues forming to use the toilet. Patients commented upon how the toilet was unsafe as it was almost impossible to safely reach the toilet roll. We checked the toilet and the roll was located beyond a set of rails designed to help a disabled person. It was very hard to reach.
  - The sink in the toilet was the only place patients were able to wash or to clean their teeth. As this area was otherwise used for day surgery patients, there were no facilities for a patient to be provided with a bed pan.
  - There was no shower. Arrangements could be made to take people to the critical care unit for a shower, but this was often impractical and would take one of the two members of staff on the unit away.
  - The overhead lights were not dimmable and so were either on or off. Patients said they had been disturbed the previous night when a patient had been admitted and there was a long conversation on the phone after midnight with a language translator. There was no natural light or windows on the unit. A patient who had been on the unit for three days said they found this depressing. There were four patients on the unit when we visited and they all said it had been noisy at night.
  - There was no entertainment system on the unit as it was not designed to be used overnight.
- The hospital was not meeting NHS England consultant-led referral to treatment time (RTT) targets in five of the six surgical specialties. Of late, the hospital performance had deteriorated. For the five specialties not meeting the RTT, the average percentage of patients treated within 18 weeks for August 2015 was 84.6% against the target of 92%. The average for the South of England NHS Commissioning area for these specialties for August 2015 was 88%. In the period April 2013 to June 2014, the hospital had been consistently meeting RTT targets across all specialties. The latest data (August 2015), as published per surgical procedure by NHS England, showed only the target percentage of ophthalmology patients were seen within 18 weeks (92.3% against the NHS operational standard of 92%).
- In each of the five months reported for the new financial year of 2015/16 (April to August) the trust had not met waiting time targets for the other surgery specialties of general, urology, trauma and orthopaedic, ear, nose and throat, and oral maxillofacial. In August, each speciality RTT performance had worsened over the previous month with the exception of urology, which had slightly improved and trauma and orthopaedic surgery had stayed the same.
- The hospital has recognised the need to improve RTT times and had established a steering group and had support from the NHS support team. Recovery to meet targets was planned for the end of the 2015/16 financial year (end of March 2016).
- Some waiting lists were reducing while others were increasing. Incomplete pathways (patients waiting to

# Surgery

start treatment) had improved in data released for August 2015 for some surgical procedures, but had increased for others. There were 1,777 patients waiting for general surgery, down from 1,873 in July. There were 881 patients waiting for urology surgery in August 2015, which was down from 1,029 in July. However, patients waiting for trauma and orthopaedic surgery had increased by 48 to 2,713, and the other specialties had also increased.

- Average (median) waiting times were above (worse than) those for the South of England NHS Commissioning area in all specialties. In August 2015 the South of England average waiting time was seven and a half weeks. The average for the six specialties at Great Western (in terms of how many patients were waiting to start treatment) was just over eight weeks.
- There was round-the-clock provision for emergency surgery, although not, as recommended by the National Emergency Laparotomy Audit 2014, a reserved dedicated emergency theatre. The hospital was a designated trauma centre but not a 'major' trauma centre where it would be required to have a reserved emergency theatre. The utilisation of the emergency theatre was 28% (including overruns) in the week and 14% on the weekends.
- The trust worked with commissioners to plan for and meet the needs of the local population. There were regular meetings and an open relationship between the stakeholders.
- The number of operations cancelled at the hospital was below (better than) the England average and the local-area average. In quarter one of 2015/16 (April to June 2015: the most recent available data) the hospital cancelled 66 elective operations (of those operations meeting the NHS cancellation criteria) compared with an average of 134 nationally and 84 in the NHS England South Central area. There were, in reality, more operations cancelled than these 66, but many of these were out of the control of the hospital. The 66 cancellations did therefore not include patients who did not arrive as scheduled, those where the patient cancelled themselves, or the patient had not followed the fasting requirements. The percentage of patients not treated within 28 days of a cancellation was also below

the England average, and had been in each quarter going back over four years. There had been one patient not treated within 28 days in quarter one of 2015/16 against the local area average of 2.75.

- There was an efficient, well-organised and well-run service available for patients to be pre-assessed for planned surgery. This included day surgery patients and most of the other elective (planned) procedures. Some specialties, such as cardiac, ophthalmology and dental, would see their own patients. The hospital ran a 'one-stop shop' arrangement so day case surgery patients who had been to see the consultant at an outpatient clinic could then attend the Cherwell unit and have their pre-operative assessment before they went home. Around 75% of patients at their outpatient appointment had used the service. Inpatients with more complex surgery would have booked appointments usually around four weeks before their planned surgery. Appointments usually took around 45 minutes with the nurse and then patients met with a healthcare assistant for other tests. Longer complex operations had more detailed assessments. So orthopaedic patients, who would attend physiotherapy and occupational therapist reviews and educational classes about rehabilitation would be booked to come to planned sessions. The consultant would also discuss consent with the patient at the end of the clinic. The service was open Monday to Friday from 8am to 8pm.
- Patients we met at one of our listening events criticised the booking system for surgery dates. One patient said they had been unable to make the first appointment for surgery made for them as they were booked to go on holiday. They then had to wait for a new appointment as one could not be made on the phone. The pre-operative assessment was then cancelled and when all the new appointments were finally arranged, the pre-operative assessment date was after the planned operation. This led to more frustration for everyone involved and additional administration for the hospital. Another patient said there was "no human element" in the booking system. If you could not make your appointment for good reasons (they had two appointments for different departments at the same time) then you had to wait "often several weeks" for the

# Surgery

next letter to arrive. Patients said it was “the luck of the draw” if you were able to make the appointment and the system did not appear to “take account of anyone who had a job or responsibilities.”

- The hospital did not operate a service for post-operative patients to contact staff in the 24 hours after they were discharged. Staff in the day surgery unit said patients were able to ring the unit for support, but this would be Monday to Friday and only in daytime hours. If they needed support over the weekend they would be requested to contact their GP out-of-hours services, the NHS 111 service, or attend A&E.
- There were good facilities for patients to wait when they were fit for discharge home but waiting for medicines or transport, for example. The discharge lounge was open from 9am to 6pm and led by nursing staff. The lounge was adjacent to Meldon ward from where staff would provide emergency support if this was needed. Patients were brought to the lounge by a trained nurse and handed over to staff. There were facilities for ongoing care such as changing dressings and giving intravenous antibiotics. There were three single rooms available for this. The unit did not have access to the electronic prescribing system, but were given a printed drug chart if medicines needed to be continued. The discharge lounge team carried out a ward round each day to help coordinate patient discharges. Food and drinks were provided for patients who had to wait through mealtimes. When they were ready to leave, patients were escorted to their transport by one of the nursing team or collected by an ambulance patient transport crew member. The only disadvantage with the discharge lounge was it was relatively small, and there were times when it was full and not all patients could be accommodated.
- One comment made by a significant number of patients was around the lack of a hot drink outside of mealtimes. Several patients said they had plenty of water, but no hot drinks outside of mealtimes. One patient said: “I find it quite depressing. I drink about 10 cups a day at home and they don’t come round with hot drinks. I wish I could just get up and make my own.” Other patients we met commented on the lack of a hot drink mid-morning or mid-afternoon. A patient we met staying on the day surgery unit overnight, who had been there three days, said they had only been given one hot drink each day. Patients admitted as inpatients to the day surgery unit had not enjoyed the food. The soup was described as “lukewarm”, and a salad as “swimming in water” and “not fresh”.
- Although most comments made to us were positive, the hospital scored below (worse than) the NHS England average for food in the PLACE (patient-led assessments of the care environment) survey in both 2013 and 2014 and the score had deteriorated from 87 in 2013 to 84 in 2014.
- Most patients had access to entertainment systems. Bedside equipment provided access to television and radio for most patients. These facilities did not extend to the three extra beds in Meldon ward, or the surgical assessment unit. There were also no entertainment facilities in the day surgery unit, although patients were able to watch television in one of the smaller waiting rooms once day surgery had finished for the day, and if they were well enough.
- There were facilities for providing patients who were delayed in leaving the recovery area with something to eat and drink. The manager of the recovery teams said staff were able to arrange for patients to have a ‘lunch box’ brought up and a drink. One of the patients we met who had been delayed in recovery for seven hours on the previous day said she had been well cared for and was given a lunch box and something to drink. When she got to the ward (late in the evening) she was offered hot toast and tea.
- Patients with additional or extra needs were supported for their admission to hospital. The hospital trust had a team of nursing staff who specialised in supporting patients with learning disabilities. Members of this team would be available to come to a ward or unit to help staff provide support for a patient with a learning

## Meeting people’s individual needs

- Almost all the patients we met had enjoyed the food. Some of the comments made included:
  - “the food was hot and pretty tasty. I enjoyed the hotpot.”
  - “there was perhaps a bit much for what I could manage, but what I ate was first class.”
  - “I only wanted a salad, but that was quite okay.”
  - “the quality of the sandwiches has dropped. I remember them being much nicer last time I was here.”

# Surgery

disability. They would also make advance arrangements to make the patient's visit to the hospital easier for the patient and any carers. This included arranging a 'walk-through' the operating theatre for a patient and their carers if this was considered helpful and appropriate. Patients visiting the pre-operative assessment unit (Cherwell) who had different or complex needs were able to use quiet rooms or given early appointments so they could be seen first. The trust had produced a booklet for patients with a learning disability called 'My Health in Hospital' and a range of Easy Read leaflets on common procedures such as having a blood test, X-ray or scan. Staff said either the patient, their main carer, or the hospital staff would complete the booklet with essential information about the patient. A number of staff commented upon how helpful the booklets were to provide more individualised care.

- Staff were doing their best with stretched resources to support patients living with dementia. The surgery wards did not, however, provide any specific prompts or enhanced signage to assist people living with dementia. For example, there were no dementia-friendly signs around the wards to help people with orientation. There were no places for people to sit other than by their bed. Patients were not able to sit at a table to eat, when it has been recognised this would often be a trigger to get confused patients to eat and drink. There was, however, plenty of light on the wards to help with reduced vision or light perception.
- There was an excellent and well-thought out range of leaflets, notice boards and displays in the waiting area of the pre-operative assessment unit (Cherwell). Wards and other units had also taken care to produce relevant and current information in terms of leaflets and notices.
- Translation services were available and had been relatively and successfully well used. There was a telephone translation service provided for general or urgent translation needs. There were also translators available to visit the unit to provide either one-off support for a specific situation, or a more planned longer-term service. The system was mentioned by staff in the pre-assessment unit (Cherwell) as something they had used and found to be good quality and effective. They had no significant delays in receiving a service with many different language needs.

## Access and flow

- Patients were moved at times to improve access and flow. There were a limited number of surgical patients being nursed in non-surgical wards elsewhere in the hospital but there was a knock-on effect from accommodating medical patients in surgical units. The clinical site managers and bed managers ring-fenced the four surgical wards on the Brunel Treatment Centre for surgical patients only. This was due primarily to the wards being located in another part of the hospital from the medical wards, and outlying medical patients would cause inefficiencies particularly for the medical team treating the patient. There were, however, medical patients placed in other areas established for surgical patients. On our Sunday unannounced visit, the 10-bed surgical assessment unit (SAU) was accommodating only medical patients and the medical assessment unit was full. This meant SAU patients could not be admitted to the SAU for overnight observations and would need to be admitted to a ward. This had the potential to displace patients from the admitting ward who were planned for admission the following day. Their surgery could potentially be cancelled (which was infrequent), or, as was more common, require the opening of the day surgery unit for admitting patients. Patients were also accommodated in the Shalbourne Suite following surgery, which was closely located to the Brunel Treatment Centre.
- There was high bed-occupancy in the hospital and delays caused by external factors. In the first quarter of 2015/16 (April to June 2015) the average occupancy was 93.7% and 95% in the previous quarter. This was against an NHS average of 88.4% and 90.7% respectively. Occupancy had not fallen below 92% in the last two years and was constantly above the England average. It has been recognised that occupancy of over 85% has an impact on the quality of patient care delivered. A rate of 85% or below gives staff flexibility to admit people in emergencies, undertake indirect patient-related tasks, such as audit work, training, and mentoring of new staff.
- There were a high number of patients who were fit for discharge, but remaining in the hospital. Although the data about delayed transfers of care were for the whole hospital (so included medical patients) there were around 10% of patients at any one time who were waiting for support to be provided at home before they

# Surgery

left the hospital. Around half of these patients were waiting for care packages in care homes or their own home. On the day of our Sunday unannounced visit to the hospital, there were 55 patients who were delayed by transfers of care. There were 27 patients in the hospital who were awaiting admission to a bed.

- There were a number of post-operative patients being delayed in the recovery area awaiting a hospital bed. This information was being recorded, although staff were not aware of how it was being used to improve services. We scanned the information. In the August 2015 records we reviewed, one patient had been delayed for eight and a half hours until 11pm. There were two patients we saw who had not been moved to a ward until 1am. A patient we met on a ward said they had been held in recovery for a long time, and it was confirmed from the record this was for seven and a half hours. Part of the recovery area had now been designated for long-stay patients so staff would be aware these patients were being significantly delayed.
- The efficiency of the operating theatres was sub-optimal. Staff were working through an improvement programme to improve efficiency. In the five months from April to August 2015 the overall efficiency of theatres (including overruns) had been 83% and the efficiency rate had fallen each month from 85% in April to 81% in August 2015. If you took out overruns, the efficiency rate fell to 78% on average with 76% in August. The problems to be resolved included the number of sessions that were late starts. This had increased from 29% in April to 44% in August. The majority of late starts were due to the patient not being ready or having consented for surgery. This was followed by late starts due to list changes, cancellations or patients who did not arrive for their procedure. The majority of the late starts were within orthopaedic surgery, followed into a distant second by general surgery.
- There was some confusion with patient bookings which was not helping this situation. On one day of our inspection a patient was booked to a surgical list and had not arrived. When checked it was discovered the patient had already been operated on the previous

week. There was another example of this on the previous day when a patient who was booked for a procedure needed to be cancelled, but it transpired they had also already had their procedure.

- There was a theatre utilisation recovery programme with plans for a 'perfect week' in November 2015. This would involve following the patient's journey through theatre from booking and pre-operative assessment, to admission, operation and recovery. Staff would be encouraged to report on what went well, what could be done better to avoid delays, and how the process might be changed to improve the experience for the patient. There was a programme to run alongside with aims and objectives to be met in this 'perfect week'. This included lists starting on time, equipment all available in the right place at the right time, all staff in theatre by 8am, the booking team contacting patients the day before their operation to confirm their arrival time, and changes to theatre schedules made only for clinical reasons.

## Learning from complaints and concerns

- The hospital provided a Patient Advice and Liaison Service (PALS) to deal with concerns and complaints. There was no evidence to suggest these were not well managed and to the satisfaction of the complainant. There were leaflets about the service available in wards, units, and relevant areas for patients or their relatives/friends. This included how to raise a concern, who to contact and when they were available. The leaflet was available in different formats on request.
- Complaints were listened to but how they made a difference to the patient experience was not clear. The planned care directorate (in which surgery services sat) provided us with a short report on complaints received and actions taken. The report was not dated so we were not able to see when these complaints had been made. The actions taken or recommended (as some of them were not yet organised) were reasonable but there was no person responsible for their implementation or to report back on their success or otherwise.
- Complaints were discussed in departmental meetings but, from minutes provided, it was only in relation to administration. In the planned care divisional board meeting from May 2015, for example, under the clinical governance section, complaints were discussed only in terms of the backlog being cleared, how many were

# Surgery

open and overdue, and how staff were thanked “for the extra push”. There was no recorded discussion as to what these complaints were, how they were being addressed, and if any actions taken had resolved any of the concerns raised. In the report for June 2015 there was a comment about how the number of complaints was growing but no comment on the nature of complaints. There was no evidence to suggest complaints were not used to improve practice, and senior staff reviewed and challenged all complaints where appropriate. But there was no record to demonstrate how this valuable and important resource was being used to improve patient experience, quality and safety.

- PALS reports were presented to the divisional board meeting. These highlighted how many complaints had been received, if targets were being met for a response, along with the trends in complaint topics. The top trend was entitled ‘communication’ which was followed by ‘waiting time’ and then ‘telecommunications’. The top two complaints had not improved from January to August 2015 and there was no evidence of how changes were being made to reduce concerns and complaints from patients and relatives.

## Are surgery services well-led?

Requires improvement



We have judged the governance of the surgery services as requiring improvement.

Many aspects of leadership in the service were excellent, but the service lacked a cohesive clinical governance structure demonstrating learning, change and improvement. The approach to risk management in the department was good in that it was reviewed regularly, but the actions designed to mitigate, reduce or remove the risks did not demonstrate expected outcomes. There were a number of good departmental meetings held, but it was unclear if and how these fed into the overall clinical governance and provided board assurance.

There was a theatre utilisation recovery programme being implemented and programme to improve the inefficient use of the operating theatres. There was a range of clinical audits undertaken, but no reporting to the divisional board of audit results or action plans.

There was good leadership and local-level support for staff. All the staff we met showed commitment to their patients, their responsibilities and one another. There was a strong camaraderie within teams with flexibility provided where possible. We were impressed with the loyalty and attitude of the staff we met.

### Vision and strategy for this service

- There was a vision and strategy for the service, but this had not been formalised or approved at board or directorate level. Each department had been charged with producing their own five year plan to present to the planned care directorate board but these were at an early stage. We were provided with a one, three and five year strategic ‘direction’ for the directorate. It was not clear, however, how this fitted with the direction of the trust board and the process for evaluating and reporting on the progress of the strategy.

### Governance, risk management and quality measurement

- The divisional risk register was being well used, but some entries had been open a long time, and actions recorded would not resolve or reduce the risk identified. The risk register in use was open to all staff to use and formally reviewed by the trust’s risk and assurance group. Risks rated above 15 were escalated to the trust board for a response. On the risk register for planned care dated September 2015 there were 47 open risks. Some of these were described by the risk they presented, but most were issues. Of these open items, nine were reported as a few days overdue for a review. There were some entries on the register going back as far as 2010 and 2011. There were mitigating actions for some of these older entries, although some of these did not resolve or propose to resolve the issues raised. For example, a risk from 2011 was around the ageing equipment in the decontamination and sterilisation division. The mitigating action was to ask procurement what the process was for purchasing new equipment with a target date of October 2015.

# Surgery

- The risk register did not indicate if actions had been completed or whether review dates had been moved onwards if actions were not completed. The results expected from the actions were not explained. For example, in the risk of the trust failing to meet referral to treatment times (rated 16 and on the register since March 2015), there were actions to have fortnightly calls with regulators and stakeholders, and improve reporting. There was no explanation as to what these actions were expected to produce or how they would contribute to the improvement programme underway. The improvement programme, which included plans to address the under-utilisation of theatres, was not recorded.
- There was a lack of departmental or divisional directorate clinical governance. The planned care directorate had a number of meetings within their governance structure. This started at specialty level with meetings within, for example, urology, trauma and orthopaedics, and ophthalmology. There was varied structure to these meetings, with some having formal agendas and attendance records and others with no recognised agenda or actions arising. There were, for example, some elements of good clinical governance in the ear, nose and throat meeting in July 2015 (such as case reviews with learning and suggestions), but no actions highlighted. There was no summary report from this meeting made to the division. The trauma and orthopaedic meeting was more formally minuted, but the minutes from the August 2015 meeting recorded mostly administrative and not clinical matters.
- There was a divisional board meeting with a section either described as 'quality report' or 'clinical governance'. The meeting was otherwise a business meeting with administrative matters discussed. The element on clinical governance did not discuss how quality and safety was being delivered to either provide the best patient care, or where it needed to be improved. For example, serious incidents were described as "all within time frame." Complaints and concerns were reported as "response rates have dropped. All to have no more than four complaints and to ensure complaints are closed before 28 days." Pressure ulcers were reported as "there are 11 overdue incidents. Volume has increased." There was no discussion as to the content of the serious incidents and complaints, or demonstrating accountability for actions and improvements. There was no discussion as to the reasons for the increase in pressure ulcers and how this rise was being addressed.
- There was no reporting to the divisional board meeting of audit results or progress of actions plans. For example, the regular audit of the World Health Organisation surgical safety checklist was not presented. The staff who would be accountable for any required improvements identified were not being challenged about improvements in quality and safety through clinical governance. The root cause analysis report from the Never Event made some recommendations, including how the quality of the checklist process was not considered, and how this carried a risk of it becoming too automated. There was no evidence of this recommendation being brought forward to clinical governance for consideration and action to improve theatre safety. The National Emergency Laparotomy Audit 2014 and Patient Audit 2015 had not been discussed at clinical governance despite a number of areas needing improvement, however the trust subsequently informed us of actions underway to meet the outstanding measures.
- There was a programme of trust audit, but neither this nor a report from an audit committee was presented to clinical governance. There was no review within clinical governance of the use of NICE guidelines or best practice, or review of compliance with guidelines for theatre management from the Royal Colleges, such as the Royal College of Anaesthetists' Accreditation Standards.
- We were told there was a plan to develop and improve clinical governance. There had been an appointment of a clinical governance facilitator and already an evolving directorate dashboard.

## Leadership of service

- There was dedicated leadership for the service with a new team recently appointed. The team recognised they had to deliver a programme of change and development, some of which might be difficult and challenging. The senior staff we spoke with were aware of areas of the surgery services where improvements and innovations could be made, as well as where

# Surgery

pressures and problems existed. There was support at local-level for the directorate team in looking to drive a programme of change where it related to quality and safety of care, and innovation and sustainability.

- There was strong and committed leadership at local ward and unit level. We were impressed with all the ward and unit managers including the matrons and sisters. There was an extensive range of experience and commitment from the leadership staff with a focus on patient care and also teamwork.

## Culture within the service

- We found the staff to be committed to their patients and their wards or units. We were impressed with the attitude of the staff we met. In conversations with staff, the things worrying them were all connected to patient care. This included delays to patient discharge, being able to provide more than just basic care, and managing risks for patient safety.
- There was strong camaraderie and much flexibility in many departments. One area that specifically stood out was the anaesthetics team. The team were focussed upon the patient with a genuine empathy for their care and wellbeing. There was strong leadership, commitment and teamwork in the pre-operative assessment unit (Cherwell). Staff spoke of how well they were supported by the unit sister. This was echoed in the recovery areas with committed leadership and enthusiastic and caring staff. We were impressed with the dedication and passion for good care by the charge nurse on the surgical assessment unit, the sisters leading the wards, the surgical matron, and the sister managing the day surgery unit.
- Staff were told of compliments about their care and treatment. We saw thank-you cards on wards for staff to read. In the operating theatre there was a notice board for patient comments. We saw a high number of compliments including staff being singled-out by patients for their kindness and care.







## Public and staff engagement

- Patients took part in PLACE (patient-led assessments of the care environment), although the results did not relate to named wards or the surgery services specifically. The results, which were mostly comparable to NHS averages, were encouraging for staff, patients and the hospital trust.
- The hospital was a Foundation Trust, which meant it had oversight from a board of governors and also members. The members were required to elect the council of governors, attend focus groups to influence the future direction of services, and be consulted on how improvements could be made. Anyone over the age of 12 living in the local community could become a member. The governors were responsible for appointing the hospital chair and non-executive directors. They were appointed to provide constructive challenge to the trust board and represent member's interests.
- Staff were enabled to join as members of the trust and were represented within the governors. All staff were appointed as trust members unless they opted out. Four staff were appointed by election of the members to the Council of Governors.

## Innovation, improvement and sustainability

- There had been innovation within surgery services. This had included a 'virtual fracture clinic' being introduced to trauma and orthopaedic services in May 2015. This service involved a clinician looking at a patient's notes and X-rays before discussing their treatment and care with them over the telephone. This was designed to save time and cost for all involved by reducing the need for attendance at the hospital for follow-up consultations and check-ups. The clinic was discussed at the clinical governance meeting for the trauma and orthopaedic division in August 2015, but a formal review would be presented in the following month. The breast surgery service delivered its first intra-operative radiotherapy in 2014/15 and has received approval for entry into the national clinical trial. This service expects to expand in 2015/16 when guidance from the National Institute for Health and Care Excellence (NICE) is released.

# Critical care

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

## Information about the service

Great Western Hospital provides a service to patients who need intensive care (described as level three care) or high dependency care (described as level two care).

Patients were admitted following complex and/or serious operations and in the event of medical and surgical emergencies. The unit provided support for all inpatient specialities within the acute hospital and to the emergency department.

The critical care unit (CCU) had 12 single occupancy rooms, with eight intensive care and four high dependency beds. The service was led by a consultant intensivist with support from the critical care consultant team and senior nurses.

In the three months from January to March 2015, the unit admitted just under 50% of its patients from elective (planned) and emergency surgical procedures and just over 50% were medical patients. Of the surgical procedures, around 20% were high-risk elective surgery and 25% emergency surgery. The number of patients treated has fluctuated over the past five years, but was usually between 200 and 250 per quarter, with approximately 900 patient admissions per year.

The CCU contributed data to the Intensive Care National Audit and Research Centre (ICNARC: an organisation reporting on performance and outcomes for around 95% of intensive care units in England, Wales and Northern Ireland). This is reflected in some of the statistical data used in this report.

On this inspection, we visited the CCU on Wednesday 30 September, Thursday 1 and Friday 2 October 2015. We spoke with a range of staff including consultants, doctors, trainee doctors, different grades of nurses, healthcare assistants, administrative support and the housekeeping team. We met with the consultant clinical lead for the service and the matron who ran the critical care nursing team. We spoke with physiotherapists, a lead nurse from the outreach team, a pharmacist, and a dietitian. We met with patients who were able to talk with us, and their relatives and friends. We checked all of the CCU clinical environment, observed care and looked at records and data.

# Critical care

## Summary of findings

We have judged the critical care services overall as requiring improvement, although with some areas of good and outstanding practice. The safety and governance arrangements required improvement. However, the service was providing effective, caring and responsive treatment and care to patients.

Incident reporting was inconsistent and opportunities for learning were not always being identified. Reviews of patient mortality and morbidity were not leading to learning in the unit, or shared across the wider trust. Mandatory training compliance was below target and there were areas of concern with infection prevention and control. Intravenous fluids were not being kept in locked storage, which left them at risk of tampering.

The unit had strong leaders but the governance arrangements were not robust or effective. There was no demonstration that lessons were being learned or of changes being made to improve the service. There was a five year strategy but it was not cited or approved by the directorate, or aligned with the trust's five year strategy. It contained areas for development and strengthening in the unit, but did not show how this could be achieved. Staff satisfaction was high and they told us managers were open, honest, fair and visible.

Care and treatment was generally planned and delivered in accordance with current evidence-based guidance, standards, best practice and legislation. Patients' needs were assessed and multidisciplinary teams worked to support treatment plans. A shortage of speech and language therapists, however, meant some patients' swallowing and communication needs were not always responded to promptly. Staff had a good knowledge of the Mental Capacity Act, Deprivation of Liberty Safeguards and restraint. Patient outcomes were monitored and reported nationally, with the unit showing it was performing well against other units. Training and development opportunities were not prioritised in the unit, and the lack of a full time clinical nurse educator risked learning needs not being identified or managed.

Patients were supported, treated with dignity and respect, and were involved as partners in their care.

Patients and their family or friends were involved with decision making. They were able to ask questions and raise anxieties and concerns and receive answers and information they could understand. Staff treated patients with kindness and warmth. The unit was busy, but staff always had time to provide individualised care. Staff talked about patients compassionately, with knowledge of their circumstances and those of their families.

Services were planned and delivered to meet the needs of the local population, with comfortable facilities available for patients and visitors. Services were equally accessible for all, and no discrimination (unintended or otherwise) was being demonstrated in how services were delivered. Facilities were, on the whole, appropriate for the services being delivered; however, overnight visitors and patients had to share a single shower room. Delays and cancellations as a result of bed unavailability in the unit were minimal; however, there were some discharge delays due to pressures with beds elsewhere in the hospital. The unit had a clear system for the investigation of complaints, including involvement of, and feedback to, patients, relatives and staff.

# Critical care

## Are critical care services safe?

Requires improvement



We have judged the critical care unit to require improvement for safety.

Incident reporting was inconsistent and opportunities for learning were therefore not always being identified. Staff were not routinely reporting near misses and no harm incidents. Trends in incidents were not regularly monitored and identified.

Regular reviews of patient mortality and morbidity were taking place, but there was no evidence these reviews were leading to learning in the unit, or shared across the wider trust. Mandatory training compliance overall was close to being in line with the trust's target; however, some areas were well below the target, with paediatric life support being a significant concern with only 31% of nurses having completed this.

There were areas of concern with infection prevention and control. We found dried staining, which appeared to be blood, on three 'clean' beds, and what appeared to be dried faeces on the underside of a 'clean' commode. Although staff responded immediately when these were raised as concerns, we found similar occurrences on subsequent days which suggested no action had been taken to deal with the source of the problem.

The unit met the majority of the safety standards of the Department of Health 'Health Building Note for Critical Care Units'. The gaps had been identified, but not entered on the risk register with an action plan outlining how and when the service would reach full compliance.

Although the majority of medicines were being stored securely, intravenous fluids were in unlocked storage in accessible areas making them vulnerable to being tampered with.

Nursing staff levels were mostly appropriate for the numbers and dependency of the patients in the unit, but there were times when the unit was not staffed by the required number of nurses.

Major incident planning and exercises were not given sufficient priority in the unit, increasing risk should a major incident occur.

## Incidents

- Staff told us they felt supported to report incidents and believed there was an open culture and a desire to learn from incident reporting. However, we were told by managers and staff that incidents were usually only reported where harm had occurred. 'Near misses' and no-harm incidents were not routinely reported, suggesting learning opportunities were being missed. For example, we observed that no incident reports had been completed for accidental removal of nasogastric tubes, which had occurred during our inspection.
- Where incident reports were completed, learning was shared through team meetings and at the morning safety brief, if required. There was a folder in the unit where incidents reported and lessons learned were recorded for all staff to review and sign to say they had read the learning points. We were given one example of an incident raised following an issue with the use of a cannula. As a result of the investigation findings, practice in the unit was changed and learning was reportedly shared with other areas of the hospital.
- Incidents were straightforward to report and staff received feedback. Staff used an electronic incident reporting system, which was easily accessible from the home page of the trust's intranet. Incident reports still under investigation could be checked by the reporting member of staff so they could check the progress. There were feedback emails to staff following an incident report being investigated and then closed; this included the findings and actions being taken as a result.
- Lessons from mortality and morbidity were not being shared. Patient mortality and morbidity reviews took place in the unit every two weeks. There was no evidence of any learning being shared following these meetings or accountability for driving change and improvement. The matron did not attend and the meetings were not routinely attended by nursing staff. Deaths were not being classified against the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) standards.
- The safety performance of the critical care unit (CCU) was good. There were low numbers of incidents of avoidable patient harm, unit-acquired infections, and errors leading to patient harm. The unit had reported no 'serious incidents' during the previous 12 months.

# Critical care

## Duty of Candour

- Although staff were not aware of the term 'duty of candour', we found there was an understanding of the requirements of the regulation. There was an open culture within the unit when things went wrong. We saw evidence that patients and/or relatives were informed when something went wrong and that appropriate apologies and feedback were given as required. Records of these actions were kept within the incident reporting system under a 'duty of candour' section.

## Safety thermometer

- Patient avoidable harm data was being reported. The unit contributed to the NHS Health and Social Care Information Centre (HSCIC), a national database collating data about avoidable patient harm arising from pressure ulcers, falls, catheter associated urinary tract infections and venous thromboembolism (deep vein thrombosis and pulmonary embolism). Data was collected on one day each month to provide a 'snapshot' of avoidable harm.
- Results were displayed for patients and visitors. The unit's performance board, located near the entrance to the unit, displayed the most recent results from the NHS safety thermometer. This showed a 12 month period of consistently low harm with the majority of months showing 100% 'harm free care'. There had been eight months of 100% harm free care. There were no reported pressure ulcers since October 2014, two months where a catheter-related urinary tract infection had been identified and one month (January 2015) where a venous thromboembolism had been identified.

## Cleanliness, infection control and hygiene

- Hand-washing facilities were readily available and infection control rules were prominently displayed. There was good access to alcohol hand rub throughout the unit, including at all entrances and exits. Every bed space had a sink, soap and paper towels for hand washing, and there were several additional hand washing sinks located within the unit.
- 'Unit rules' posters were displayed throughout the unit, including at all entrances and bed spaces. These stated all staff must be 'bare below the elbows', use alcohol gel

when entering and leaving a patient's room, put on an apron and gloves before examining a patient, and then remove apron and gloves and wash hands after examining a patient.

- Staff were not always seen to observe good hygiene practise or adhere to the unit 'rules'. We observed on multiple occasions staff not using alcohol hand rub prior to entering or leaving a bed space. There were occasions where personal protective equipment (PPE: aprons and gloves) was not put on before patient contact, some limited use of sinks and soap for hand washing, and occasions where notes were examined and updated while PPE was still being worn. Critical care staff were observed to be bare below the elbows at all times. This was not always the case, however, with visiting staff. For example, we saw one surgeon wearing a suit jacket with long sleeves in the unit and another surgeon wearing a wrist watch while in the unit.
- Cleaning in bed spaces was not always effective. On three consecutive days we checked bed spaces that had been cleaned and signed off ready for patient admission. On each occasion we had to raise immediate concerns with the senior nurse because the spaces were not visibly clean. On one occasion we found a bed frame that had dried staining, which looked like blood, and a missing cover for the mattress. On another occasion we found a bed with dried staining, which appeared to be blood, on the bed base and raising arms. On the third occasion we found the underside of the bed had dried staining (which appeared to be body fluids), dust on the overhead pendant and black staining from dirt on the floor edges. The beds were immediately cleaned by nursing staff on each occasion, and staff from the cleaning contractor attended to clean the floor space and overhead pendant.
- Equipment cleaning was not always effective. One commode labelled as clean had visible dried staining underneath, which appeared to be faeces. We raised this with the senior nurse who immediately ensured it was thoroughly cleaned. The wheels of the drip stands were also not clean and did not appear to be routinely addressed by the cleaning team.
- Internal audits of cleanliness and infection control were contradictory. We requested evidence of environmental audits to demonstrate how infection prevention and control and cleanliness were monitored. We were sent a

# Critical care

sample of hand-written audits from the critical care unit. Alongside this was an infection control summary audit for all wards areas, with a separate summary section for critical care. In terms of contradiction, on 31 July 2015 a departmental infection prevention and control audit was completed by the matron and Infection Prevention and Control staff. This audit scored 52% compliance, with issues being highlighted around cleanliness of bed rails, lockers and tables, blood pressure cuffs, computers, storage units and dust in multiple locations throughout. A further follow-up audit was completed on 6 August 2015 and scored 73%, with storage racking found to still be dusty and bed rails, storage units and drip stands not being clean in all cases. There was no evidence of any action plans to address the findings. The trust departmental self-audit data for July and August 2015 showed 97% and 98% compliance, respectively, for equipment cleanliness.

- There were basic facilities for patient isolation. The unit had one 'negative pressure' room, where air was extracted to the outside, but this was not a room established as recommended by the Department of Health for specific patient isolation. The unit did not have a room with a gowning area, which would provide extra protection to other patients, visitors and staff from a patient in isolation.
- For infection control purposes, the unit policy was for each bed space to have a dedicated stethoscope. Staff were not permitted to use personal stethoscopes within the unit; however, we observed some doctors had personal stethoscopes around their necks, including during patient assessments and treatments.
- Rates for acquired infections on the CCU were low. Data reported to the Intensive Care National Audit and Research Centre (ICNARC: an organisation reporting on performance and outcomes for around 95% of intensive care units in England, Wales and Northern Ireland) supported this evidence. All rates of infection had mostly been below (better than) the national average over the past five years.
- There had been no unit-acquired Methicillin-resistant *Staphylococcus aureus* (MRSA) infections in the 12 months to March 2015 (the most recent data provided). This was better than the national average over a year.

- There had been no unit-acquired MRSA infections in blood reported for the 12 months to March 2015. Patients were effectively screened for MRSA on admission and again every week. Patient records demonstrated this level of screening was taking place
- There was one patient with unit-acquired *Clostridium difficile* in the same period, which was, however, still below (better than) the national average.

## Environment and equipment

- The unit met the majority of the safety standards of the Department of Health 'Health Building Note for Critical Care Units'. The gaps had been identified, but not, as recommended in the Core Standards for Intensive Care Units (2013), entered on the risk register with an action plan outlining how and when the service would reach full compliance.
- Some of the ways the unit did meet guidelines were:
  - The main theatre complex was located immediately beside the critical care unit for accessing emergency support;
  - The bed spaces were of a suitable size for, in an emergency, giving up to five staff enough space to work safely with a patient;
  - There were separate buttons for patient call bells and emergency calls;
  - Each bed had at least one feeding pump;
  - There were sufficient oxygen, four-bar air, and vacuum outlets;
  - There was a good level of mobile equipment available including haemofiltration machines, portable X-ray available, a defibrillator and cardiac output monitors;
  - There were separate entrances and exits for staff and patients, and visitors;
  - Each room had a ceiling mounted, twin-armed pendant for the provision of medical gases, electrical and data connectivity and other equipment;
  - CCTV and intercom entry systems were accessible from the central desk areas.
- Some of the ways the unit failed to meet the guidelines were:
  - All bed spaces had 24 un-switched sockets, not 28 as required. Additional sockets were available, but these were switched, which risks them being turned off inadvertently;

# Critical care

- None of the bed spaces had a ceiling mounted hoist for lifting patients.
- There was equipment for specific use with a child admitted to the unit, but checks were not carried out consistently. The unit's paediatric admission trolley had a weekly check sign-off sheet, which was also for completion after each use of this equipment. The sign-off sheet we checked had not been completed for two weeks. We looked at the records back to 26 September 2014 and saw there were some gaps where the checklist had not been completed for up to six weeks. We informed the matron of our observations and were told that it had been checked earlier that week because it had been used, but the sheet had not been completed.
- Standard checklists for patient bed areas were completed daily, with more in-depth checks weekly, to confirm equipment and the bed areas were prepared for use. Additionally, patients' observation charts recorded daily equipment checks, including equipment trays, syringe pumps, suction equipment, intravenous lines and feeding tubes.
- There was safe provision of resuscitation equipment. The unit's adult and paediatric resuscitation trolleys were both readily available in an accessible central location. Both were tamper-evident and sealed with numbered tags. Daily and more detailed weekly checks of the equipment and contents were completed and recorded. We checked the records for the three months prior to our visit and found them to be completed as required.
- There was emergency equipment for treating patients with airway complications. There was a difficult airway trolley co-located with the resuscitation trolleys, providing quick access to emergency airway equipment. We checked the trolley and found all required equipment was available, in date and readily accessible.
- The unit had a dedicated patient transfer trolley and equipment. The non-medical equipment and supplies were checked daily by the healthcare assistants, while the medical equipment and supplies were checked daily by the doctors. Evidence of these checks was recorded in a folder located with the equipment.
- Imaging equipment was used safely. The unit had a portable X-ray machine, which we observed being used

on a couple of occasions. During each use the operator prepared the machine and patient, then gave a clear verbal warning to staff and visitors in the unit that an X-ray was about to take place so they could ensure they were clear from the immediate area.

- The unit had equipment servicing and replacement programmes to ensure patient safety. We reviewed equipment inventories and servicing records and saw regular servicing and software updates were completed in accordance with schedules. There was a replacement programme for large equipment in the unit, with life expectancy and planned replacement dates being recorded and monitored. All equipment was within its life expectancy limits, with the exception of three machines used to provide a continuous positive airway pressure to patients. These were due for replacement in 2010. The devices were scheduled to be replaced this year, with a budget set aside for this.
- Clinical waste was effectively and safely managed. Single-use items of equipment were disposed of appropriately, either in clinical waste bins or sharp-instrument containers. There was a full range of disposable items in order to avoid the need to sterilise equipment and reduce the risks of cross-contamination. Staff were using and disposing of single-use equipment safely. None of the waste bins or containers for disposal of clinical waste or sharp items we saw were unacceptably full. Staff told us waste bins were emptied regularly.

## Medicines

- Most, but not all medicines were stored appropriately. Although the controlled drugs were locked inside an approved metal cabinet, the cabinet was not within a locked room. However, the area was within the main unit and under observation, either visibly or audibly. Intravenous fluids were not being kept securely as they were in unlocked drawers in an open plan clinical areas. They were readily accessible to anyone within the unit and were therefore vulnerable to tampering. This was the case in both the central storage area and the unit's store room, which had an unlocked door that was left open at all times during our inspection.
- Refrigerated medicines were stored safely. The temperature of the unit's drug fridge was checked and

# Critical care

recorded daily. The fridge contents were also regularly audited and recorded. In accordance with trust policy, the fridge was not locked because emergency drugs needed to be readily available.

- The fridge in the critical care unit was located near the central nurses' station in the main ward area. The unit was secure (having close proximity security access for staff, and an intercom system for visitors); however, visitors and patients once in the unit had access to the area where the fridge was located. The fridge was observed the majority of the time, but there were times that this was not the case.
- There was a system to ensure medicines were available at all times. When a patient required urgent medicines their prescribing chart would sometimes be sent to the pharmacy (located next door to the unit) to be checked and the medicine prepared. If the patient was, however, extremely unwell and removal of their prescription chart would be unsafe, a pharmacist would urgently attend the unit to review the chart, or it would be faxed to the pharmacy. There was an incident reported recently where a patient's prescription chart was sent to the pharmacy and subsequently lost. After the investigation, the process was improved to prevent recurrence. There had been no further instances of drugs charts being lost in this way. Additionally, a new module for the trust's electronic prescribing system was to be reviewed later this year to see if it would be suitable for use in the unit. Having an electronic prescribing system would meet the recommendations of the Core Standards for Intensive Care Units (2013).
- Patient medicines were secure. Patients who arrived in the unit with their own medicines had these locked in a drawer beside their bed. Any controlled drugs arriving with a patient were kept in the controlled drugs cabinet with a separate register used to record them.
- Controlled drugs were managed in line with legislation. The drugs, in terms of their booking into stock, administration to a patient, and any destruction, were recorded clearly in the controlled drug register. We checked drugs in tablet (all boxed) and liquid form, and stocks of liquid potassium chloride 15% W/V which should also be, and was, stored as a controlled drug. Stocks were accurate against the records in all those we checked at random in the CCU. We cross-referenced one of the drugs with a patient drug chart and found the

drug had been documented as administered on the occasions and at the dosage stated on the record. The controlled drugs were audited daily, with evidence of these checks being completed recorded clearly in the record book.

## Records

- Patient records had not always been kept securely, but this was addressed during the inspection. On our arrival we found patients' care records were being stored on tables outside the bed spaces. We raised immediate concerns with unit managers that this did not protect the confidentiality of the records. It left them potentially open to access and/or tampering by anybody in the unit, including visitors. The following day we found the unit had responded to our concerns and had started storing the care records within the patients' rooms.
- Patients were given medication in their best interests, but this was not always appropriately recorded. One patient in the unit was reported to be receiving covert medication (the medication was being hidden so the patient was unaware they were taking it, but it was given in their best interests). We reviewed the records for this patient with the nurse who was caring for them and were unable to find any documentation to support this. Staff said a discussion had taken place between a pharmacist, critical care doctor and psychiatric team the previous day. At this meeting it was agreed this was an appropriate course of action because the patient had been refusing medication, lacked capacity to make this decision and was subject to a Deprivation of Liberty Safeguards authorisation. A retrospective entry was then made on the patient's care record.
- Care records were well completed, although there were some gaps. We reviewed eight care records and found the majority of these were completed appropriately and accurately. There were some omissions. For example, the time of decision to admit the patient to critical care was not recorded in four cases, allergy information was not recorded in one case, and risk assessments and associated care plans were not fully complete in two cases. Audits of care records were not being completed in a structured manner so areas for improvement were not always being identified.
- The unit was using its own bespoke observation chart to meet the needs of the patient. This was a large paper

# Critical care

record sheet covering a 24 hour period and incorporated all the observations required to monitor the patient and keep staff informed of relevant changes to the patient's health. It included all the areas we would expect to see. All the observational charts we reviewed were completed as required and timed, dated, legible and clear.

## Safeguarding

- There were clear processes for responding to and reporting any suspicions of abuse. The unit had a clear safeguarding process aligned to the trust's policy on safeguarding vulnerable adults and children. Staff were able to tell us how they would raise and respond to a safeguarding concern, and demonstrated how to locate the relevant procedures and paperwork.
- The unit's safeguarding folder contained useful information including examples of different safeguarding concerns. This included, for example, different types of abuse, as well as a safeguarding quick reference guide. This was readily available and staff were familiar with its contents and layout.

## Mandatory training

- Not all staff had updated their mandatory training. The trust's target for updates to mandatory training was for 80% of staff to be compliant at all times. Overall, mandatory training compliance for critical care was 77%. Some key subjects were below target, such as consent, mental capacity and Deprivation of Liberty Safeguards (77%) and only 31% of nurses had completed paediatric basic life support training. Records showed children were cared for on the unit in an emergency at least once per month. No members of staff had completed their level two safeguarding vulnerable adults' awareness training. One medical trainee we spoke with had recently joined the unit; they had completed the trust and unit induction programme, which included mandatory training.

## Assessing and responding to patient risk

- There was a hospital-wide approach for detection of the deteriorating patient, but the system used was not standardised. The hospital was using a mixture of the Swindon Outreach Score (SOS) and the National Early Warning Score (NEWS) to identify patients who were deteriorating. Both systems took patient observations to

calculate a score which in turn indicated how serious the patient's condition was and what further actions were required to monitor and escalate the patient's care. The SOS system was used in all inpatient areas, while the NEWS system was used in the emergency unit, medical assessment unit and ambulatory care. Both systems had trigger points at which the critical care outreach team would be contacted. There was a plan to make the NEWS system the standard across the whole hospital over the coming months.

- The unit provided an outreach service between 8am and 4pm seven days a week to respond to deteriorating patients in other areas of the hospital. This service provided critical care input and assessment to patient care on the wards to support the ward nurses. This included contributing to decisions about whether a patient needed to be admitted to critical care. Outside of these hours any assistance and/or advice required elsewhere in the hospital went through the duty doctor in the critical care unit.
- Staff raised concerns with us that at times deteriorating patients had not been referred at the earliest opportunity because ward staff were waiting for the outreach team to start at 8am. There was no evidence of incident reports being made for this concern. However a programme had been introduced to monitor this as part of the deteriorating patient work stream. . The lack of a service over 24 hour a day (as recommended by the Faculty of Intensive Care Medicine) was, however, on the departmental risk register.
- All patients discharged from critical care to another hospital ward received follow up support from the outreach team within 24 hours.
- The unit was using comprehensive risk assessments. Identified risks to patients were minimised through effective care planning. For example, we saw a falls assessment for one patient who was mobile, and a care plan to support them and keep them safe. There were risk assessments and care plans for pressure ulcers and venous thromboembolism.
- Patients were regularly reviewed by staff for any emerging safety risks. Staff responded in a timely

# Critical care

manner when new risks arose. For example, one patient in the unit was assessed as being a risk to them self so staff removed all moveable equipment that could be safely stored elsewhere for the patient's own safety.

- Patients were closely monitored at all times so staff could respond to any deterioration to their health. Where possible, nurses were placed with the same patient throughout the patient's stay so there was consistency of approach. An indication of something starting to change for the patient should then be picked up faster as patient care and response was closely supervised by a small cohort of nurses at all times.
- Patients were monitored for different risk indicators. The unit had equipment with each patient to monitor carbon dioxide levels in airways (capnography). This equipment provided a rapid indication if something was not right with the patient's breathing.

## Nursing staffing

- Nursing staffing levels in the unit were not always safe for the numbers of patients being admitted. There were not enough nurses to be able to operate at full capacity. The unit had eight beds for patients who required intensive care (level three), and four beds for patients who required high dependency care (level two). The Core Standards for Intensive Care Units (2013) recommend a ratio of one nurse to care for one level three patient at all times, and one nurse to care for two level two patients. Additionally, the Core Standards for Intensive Care Units (2013) recommend one nurse to supervise the unit and not be directly involved with specific patient care (supernumerary), and suggests a second supernumerary nurse where units have between 11 and 20 beds. With the unit's configuration, it required 10 nurses in their establishment model, and at least one supernumerary nurse to operate at full capacity. The unit was only funded for six level three and four level two patients, requiring eight nurses and one supernumerary coordinator. However, this staffing level was not always being achieved, with there often being only seven nurses and one sister, who was not supernumerary. Because the unit was often operating at increased capacity and staffing levels were not always able to be matched to the dependency of the patients, the Core Standards were not always being achieved.
- There were times when the unit did not have sufficient staffing for the dependency level of the patients. In these instances there was a system to send text messages to off duty staff requesting assistance, but we were told this did not always resolve the issue. Late notice agency cover was hard to arrange. The unit's risk register recorded that the ban on premium agency usage was impacting on safe critical care staffing numbers because it was difficult to get trained critical care nurses at times.
- Nursing staff were often moved to other areas of the hospital to work because of staff shortages on other wards. Staff told us that this often meant reducing staffing numbers in the unit to below the required establishment. This was on the unit's risk register.
- The unit did not have a fully established nurse group. Five additional nurses had recently been recruited to cover two vacancies and three maternity leave gaps. However, there were still 1.89 whole time equivalent posts unfilled and recruitment was ongoing. We were told the unit hoped to be fully established with nursing staff by November 2015.
- There was no supernumerary nurse in charge of the unit as recommended by the Core Standards for Intensive Care Units (2013). The senior nurse post, required for coordination of the unit, was not funded as supernumerary and was being counted within the nursing to patient ratio.
- The unit employed healthcare assistants to assist with some tasks, but there were only two in post so they were not available at all times. When a healthcare assistant was on duty they took responsibility for equipment and stock checking, as well as some basic care and treatment needs. We saw these staff had appropriate training plans to support their development.
- Patient safety was improved by limiting use of agency staff (or bank staff who were not the trust's own staff) to a minimum. The Core Standards for Intensive Care Units (2013) recommended there were not more than 20% of bank or agency staff on each shift. The data we reviewed for the last twelve months did not show any shifts had reached this level of temporary staff use. The highest use of agency staff was 6.2% of the nursing team in February 2015 and the lowest was 0.9% in September 2014.

# Critical care

## Medical staffing

- Medical staffing in the critical care unit generally met professional standards, but at times this was not the case. Consultant intensivists worked a set block pattern to ensure 24 hour a day, seven day a week cover, and to provide consistency of care for patients in the unit. Elements of this cover included on-call arrangements.
- There was minimal use of locum cover, with no locum consultants being used. Those registrar doctors employed as locums were used regularly and known to the unit staff.
- During the day there was a specialist registrar doctor on duty with a foundation year two or another specialist registrar. This met the recommendation of the Core Standards for Intensive Care Units (2013). Overnight, however, there were times when there was only one specialist registrar in the unit from 8pm to 8am. The single specialist registrar on duty at night did not meet recommended safe levels of cover when there were more than eight patients on the unit, which with high occupancy level, there often were. The unit had identified this and were working towards achieving this standard.
- The unit was able to have a consultant on site within 30 minutes during the on-call period. Only one consultant lived outside the 30 minute response time required for on-call cover. When they were on call they stayed locally to ensure they could attend the unit promptly.
- There was a safe medical handover. We observed two morning ward rounds that were attended by the previous night shift's lead doctor, the day shift's consultant and doctors and the nurse in charge for the day shift. Each patient was reviewed in turn with discussions covering their admission history, relevant observations and medications. Any changes or interventions that had taken place overnight were highlighted along with any other relevant information and what actions were required that day.
- At the end of the ward round a safety briefing took place, which covered important safety considerations for the patients and shift ahead, including staffing numbers, acuity of patients and other pertinent patient information.

- The trust had a major incident plan, which included action cards with specific instructions for critical care staff to follow. However, this was not readily available within the unit and staff were not fully aware of their responsibilities in the event of a major incident.
- We were told that a recent major incident training exercise had taken place but critical care had not been invited or informed. The unit only knew about the exercise when a simulated casualty arrived at the unit.
- The hospital had the ability to temporarily increase its capacity to care for critically-ill patients in a major incident such as a pandemic flu crisis or serious public incident. This would involve primarily using the anaesthetic rooms and recovery unit in theatres which was adjacent to the unit. In these areas staff were trained in caring for critically ill patients and would be supported by the critical care team.

## Are critical care services effective?

Good



We have judged the effectiveness of the critical care unit to be good.

We found that the care and treatment being provided was planned and delivered in accordance with current evidence-based guidance, standards, best practice and legislation. Patients' needs were being assessed and relevant multidisciplinary teams supported treatment plans. A shortage of dietitians and speech and language therapists meant, however, some patients' nutritional, swallowing and communication needs were not always responded to promptly.

Staff had good knowledge of the Mental Capacity Act and were able to demonstrate good practice and record keeping in this area. Staff also had good knowledge of the Deprivation of Liberty Safeguards and restraint. Information was available at all times to support staff in these areas.

Patient outcomes were being monitored and reported nationally, with the unit showing they were performing well

## Major incident awareness and training

# Critical care

against other units. Training and development opportunities were available but the lack of a full time clinical nurse educator risked learning needs not being identified or managed.

The trust had a yearly appraisal system and staff told us they found these useful, relevant and supportive. Appraisals included a 360o assessment from colleagues, providing a good feedback tool for personal development. However, the unit was below the trust target for appraisal completion.

Information was readily available when required, and processes ensured records travelled with a patient when being discharged from the unit.

## Evidence-based care and treatment

- There was no admissions protocol or policy. Instead the unit operated a system where any staff concerned about a patient in their care could contact the outreach team for discussion. However, where a patient was known to require critical care admission, for example after complex surgery requiring organ support, planned admissions were booked and emergency admissions were accommodated.
- Patients were safely ventilated using specialist equipment and techniques in accordance with national best practice. This included mechanical invasive ventilation to assist or replace the patient's spontaneous breathing using endotracheal tubes (through the mouth or nose into the trachea) or tracheostomies (through the windpipe in the trachea). The unit also used non-invasive ventilation to help patients with their breathing, using masks or similar devices. All ventilated patients were constantly reviewed and checks made and recorded hourly.
- Patients were sedated in accordance with national best practice. The unit had a sedation policy in place with an assistive flowchart for staff to follow. Sedation holds (a daily period where sedation is paused to limit drug accumulation, promote a more awake state and permit further assessment of a patient) were completed every morning.
- The critical care unit met best practice guidance by promoting and participating in a programme of organ donation led nationally by NHS Blood and Transplant. As is best practice, critical care led on organ-donation work for the trust. In the NHS there are always a limited number of patients suitable for organ donation for a number of reasons. The vast majority of suitable donors will be those cared for in a critical care unit. The trust had appointed one of the experienced consultant intensivists as the clinical lead for organ donation, who was also the regional lead. There was a specialist nurse for organ donation (employed by NHS Blood and Transplant) to directly support the organ donation programme and work alongside the clinical lead.
- The hospital trust followed NICE guideline CG135: Organ donation for transplantation and had a policy based around this guidance for identification, referral and approach to families of potential organ and tissue donors. The trust also had an active organ donation committee and worked locally to raise awareness. As well as critical care staff, this committee included a patient representative, the chaplain, a consultant eye surgeon and a renal physician. There was a display organised in the reception area of the hospital to coincide with national transplant week in September 2015.
- We met with the clinical lead for organ donation who had been leading on this role since 2007. We reviewed data about donations from the hospital for the period from 1 April 2014 to 31 March 2015. There had been 39 patients eligible for organ donation during this period. Of these, 18 families were approached to discuss donation. All of these families (100%) were approached with the involvement of the specialist nurse, against a national average of 78%. Evidence has shown there is a higher success rate for organ donation if a specialist nurse is involved with discussions with the family.
- Eight patients went on to be organ donors and 30 organs were retrieved and transplanted to 26 people. The average number of 3.4 organs donated per donor (even if not all went on to be suitable for use) was the same as the UK average.
- The unit was not fully compliant with the Core Standards for Intensive Care Units (2013). A review had been completed by the critical care service, which identified several areas where the recommended standards were not being met. These included:

# Critical care

- Eligible patients were not receiving rehabilitation prescriptions: a recommendation made by the National Institute for Health and Care Excellence (NICE).
- Patients were not being screened for delirium.
- The Core Standards for Intensive Care Units (2013) recommend all patients should have their rehabilitation needs assessed in accordance with the National Institute for Health and Clinical Excellence (NICE) 83 within 24 hours of admission to critical care, and eligible patients being discharged from critical care must receive a rehabilitation prescription. This standard was only being met for trauma patients, but a target to achieve this standard within the next three years had been set. The unit had met with the physiotherapy team to explore this and work was ongoing to review the physiotherapy service to see how this could be achieved in the future.
- The unit had participated in a self-assessment review against the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recommendations for tracheostomy care. Of the 26 recommendations, 15 were met in full, 10 were partially met and one was not being met. Actions required to become compliant with all the recommendations had been recorded. The recommendations not being met, either in full or in part, included:
  - Setting out core competencies for the care of tracheostomy patients
  - Careful consideration should be given to the use of a cuffed tube on discharge from critical care.

## Pain relief

- Patients' pain was well-managed. Regular assessment of a patient's pain using assessment tools took place, and plans to manage any pain were quickly started. Pain scores were recorded on patients' observation charts at hourly intervals.
- None of the patients we spoke with were in any pain and there was evidence of pain assessments, both verbal and non-verbal, and administration of pain relief in all records we reviewed. One patient, commenting positively on the care they were receiving, told us they were "not allowed to be in pain".

- The unit had access to pain nurses and consultants and told us they had a good working relationship with these teams.

## Nutrition and hydration

- Patients' nutrition and hydration needs were being met. The unit monitored and responded to their patients' hydration needs using fluid balance charts to regularly monitor and manage hydration. Patients' nutritional intake was recorded and monitored daily, with dietitians being asked to review patients where specialist input was required.
- Patients were supported to eat and drink. Patients who were able to feed themselves were given the time and opportunity to do so. Food and drink was placed near the patient so they could easily reach it. Patients who required assistance were helped by nurses or healthcare assistants.
- There was insufficient time provided by the dietetics service. We spoke to one dietitian who told us there was not a lot of funding for their specialist input with the critical care unit. They were only allocated about one and half hours per week based on the bed numbers in the unit. This did not meet the recommendations of the Faculty of Intensive Care Medicine Core Standards. For a unit of this size, there should be input from a dietician each day and involvement with the multidisciplinary team. The time provided by the dietician was dedicated to patients who needed specific specialist input. Patients' nutritional needs were otherwise generally managed by the nursing staff following agreed standard feeding protocols written up by dietitians. There were standard dietician-designed procedures for patients using nasogastric feeds, with dietitians reviewing these specific patients. A referral process had been developed to obtain dietitian input where required, with a target response time of two days. A dietitian was available on-call out of hours for support where required.
- Not all swallowing assessments were completed for patients at the earliest opportunity. Input from speech and language therapists was insufficient due to a shortage of staff. The Core Standards for Intensive Care Units (2013) recommend all tracheostomy patients should have their communication and swallowing needs assessed when the decision to wean from the ventilator has been made. This meant the unit were not

# Critical care

meeting the recommendations of the Core Standards for Intensive Care Units (2013), which the critical care unit recognised. Staff had taken actions to reduce any risks. This had included a small number of critical care nurses receiving additional training to allow them to complete a swallowing assessment on lower-risk patients. Additional training sessions were being planned to allow more critical care nurses to complete swallowing assessments.

- The unit did not have facilities to keep food warm. Food was prepared by the hospital catering department and then transported to the unit by trolley, but this could not be kept warm for patients or stored until a patient was ready to eat.

## Patient outcomes

- Patient outcomes were routinely captured and monitored against those achieved nationally. The CCU demonstrated continuous patient data contributions to ICNARC for at least the last five years. Data contribution met the recommendations of the Core Standards for Intensive Care Units (2013): a set of recognised guidelines for intensive care units to achieve for optimal care. This participation provided the CCU with data benchmarked against other units in the programme and units similar in their size and patient type. The data returned was adjusted for the health of the patient upon admission to allow the quality of the clinical care provided to come through the results. The CCU had been contributing a high standard of data: meaning the records submitted were mostly complete and could be evaluated and compared.
- Almost all patients were able to be admitted to the CCU at Great Western Hospital when they needed to be. There had been no transfers out to other hospitals for non-clinical reasons in the 12 months to March 2015 and almost none in the last five years. It has been recognised through research as sub-optimal to move a patient to another hospital critical care unit without careful planning and management. According to ICNARC data some CCU patients were transferred to other units for non-clinical reasons, although infrequently and below (better than) average when compared over time with other similar units.
- Mortality levels for patients admitted to the CCU had recently been slightly below (better than) expected

levels. This rate was much the same as the national average over time. Mortality levels for the three months from January to March 2015 were below (better than) the national average and expected levels. In the three month period from January to March 2015 there were 31 deaths. This was against a prediction (calculated from measures of the patients' health indicators taken around admission time) of 36 deaths (ICNARC 2013 model). Over the past five years, the ICNARC data showed a small improving trend in mortality.

- Some patients, but usually numbers below (better than) average, were discharged before they were ready. Statistics from ICNARC for the CCU described a small number of patients possibly discharged prematurely:
  - Early discharges were occasionally one or two in a month, with 12 patients in total in the last 12 months due to a spike in the July to September 2014 quarter.
  - Early readmissions to the unit (those readmitted within 48 hours of discharge to a ward) for the 12 months to March 2015 were mostly below (better than) the national average in each quarter, although slightly above in the first quarter. In the previous year, early readmissions had been above the national average, but the rate had fallen to none occurring in the March to June 2015 quarter.
  - The late readmissions (those readmitted later than 48 hours following discharge but within the same hospital stay) fluctuated, but of late were below the national average. In the quarter March to June 2015, five patients had been late readmissions. This was much the same as the national average. Previous to this, and for the last five years, there had been fluctuations above and below the average, but most results were below the average.
  - One indicator of patients being discharged too early was post-unit deaths and these fluctuated but, recently, were below (better than) those of similar units. These were patients who died before ultimate discharge from hospital, excluding those discharged for palliative care.
- Early or late readmissions can indicate a patient was discharged too early. Due to the nature of critical care illness it is recognised, however, that a number of these patients could return to the unit for conditions unrelated to their original admission.

# Critical care

- Patients were staying on the unit for less than (better than) the national average length of time. It has been recognised through research as sub-optimal in social and psychological terms for patients to remain in critical care for longer than necessary. Patients' length of stay was submitted to the Intensive Care National Audit and Research Centre (ICNARC; an organisation reporting on performance and outcomes for intensive care patients). The measure was benchmarked both nationally and against other adult critical care units of a similar type and patient group participating in the ICNARC programme. The length of stay had been mostly below the national average in much of the last five years. The length of stay for all admissions in the critical care unit in the year from April 2014 to March 2015 was around 3.5 days, compared with the national average of around 4.5 days.
- Overall appraisal rates in the unit were below the trust target. The trust had a target of 90% completion of appraisals within a 12 month period but trust data showed the unit was only achieving 77% overall.
- Staff told us they felt their yearly appraisals were useful, relevant and supportive. As part of the appraisal process staff completed a 360o review, which involved completing a self-assessment and asking five other members of staff from varying roles in the unit to also complete anonymous feedback to give a rounded picture of the individual's strengths and weaknesses. Staff found this a useful exercise.
- Revalidation, a process where doctors are required to evidence to their professional body that they are up to date and fit to practise, was an ongoing process supported within the unit. Medical staff undertook yearly comprehensive appraisals to support the registration process with their professional bodies.

## Competent staff

- New staff were supported when they joined the unit. The induction process for new staff lasted either two weeks for staff with experience in intensive care, or one month for those who had limited experience. This ensured they were completely familiar with the unit, equipment and working practices. Staff were allocated a mentor to help them adjust and familiarise themselves with the role when they started working in the unit. As part of the mentorship programme there were monthly reviews between the mentor and staff member to monitor progress and help identify areas of strengths and weaknesses.
- The unit was just below the recommended standard for the number of nursing staff holding a critical care nursing award. The Core Standards for Intensive Care Units (2013) recommended a minimum of 50% of the registered nursing staffing to have a post-registration award in critical care nursing, but the unit was just below this target (49%) due to some recent staff turnover. Some additional nursing staff were already undertaking the course so the unit could meet the standard. In the unit's analysis of how it met the Core Standard, it stated "...with a number of potential retirements over the next few years [the unit] need to invest in significant training now to stop the gap worsening." This was not on the unit's risk register.
- There was insufficient time given to educational development of nursing staff. The unit did not have a dedicated clinical nurse educator. The Core Standards for Intensive Care Units (2013) recommend all critical care units to have a dedicated clinical nurse educator responsible for coordinating the education, training and continuous professional development framework for critical care nursing staff. The part-time matron had clinical education within their role. They were, however, also the matron for another 35 bedded respiratory/medical ward and, we were told, there was no time available to focus on clinical education for critical care. There was no plan in place for the unit to achieve this core standard because of a lack of funding, although the issue had been raised with the directorate management team.
- One of the part-time Band 6 nurses was responsible for practice development coordination, but there was no protected time within their duties to focus on this element of their role.
- Staff had access to training and personal development. Staff told us there were training opportunities available for personal development and where they expressed an interest to attend it was supported by the leadership team.

# Critical care

- The unit held bi-weekly teaching sessions using both classroom-based learning and simulated scenarios. All staff were expected to attend and we were told that uptake was good among all staff groups.
- Some critical care nurses had received additional training to complete basic swallowing assessments on some patients; this allowed them to commence nutritional support without the need for input from a speech and language therapist. We were told that more training was planned for those staff who had not received this training.

## Multidisciplinary working

- There were mostly good multidisciplinary working arrangements in place; however, there was limited regular input from some specialties. We attended two morning ward rounds and on both occasions there was a pharmacist and physiotherapist in attendance. We saw physiotherapists and pharmacists working in the unit throughout the day, with good working relationships being seen with critical care staff.
- We saw nursing staff assisting physiotherapists and physiotherapists assisting nurses. Physiotherapists had a dedicated section within a patient's care record for the recording of their assessments and treatments. This was then accessible to other physiotherapists, as well as the nursing and medical staff in the unit to ensure multidisciplinary understanding.
- Staff told us that microbiologists would attend the unit as needed, and twice a week would form part of the morning ward round. There were strong links with the end of life care team and staff worked closely with them to strengthen support to patients and their families at the end of a patient's life.
- Dietitians did not form part of the regular multidisciplinary team, but did have input when requested by the critical care staff. Dietitians worked Monday to Friday 9am to 5pm and were a small team covering the whole hospital. They were only able to attend the unit if a patient was referred to them or was already under their care prior to being admitted to critical care. When dietitians were involved in a patient's care, they worked well with the wider team to ensure the patient was fully supported.

- We were told by unit managers that the hospital had a shortage of speech and language therapists, so regular multidisciplinary input was limited.
- There were no standard step down, discharge or handover policies in place to support the multidisciplinary team. There was a policy in place for the transfer of critically unwell patients to other hospitals, either for clinical or capacity issues, but no other policies were in place to standardise processes and information when patients were being moved to other areas of the hospital.
- General practitioners were included in communications when patients were discharged, however some important information was not shared. Discharge summaries were completed for all patients and copied to patients' GPs. Although these included lots of useful information, for example the reason for admission, any organ support provided, infection status and any ongoing issues, some important information, including nutritional information and resuscitation status, was not included.

## Seven-day services

- There was good access to services seven days a week. Physiotherapy was available seven days a week between 8:30am and 4:30pm, with on-call availability outside of these hours for respiratory patients. Imaging, pharmacy and microbiology were all available seven days a week, with out of hours' access available where required through an on-call system.
- Consultants were available 24 hours a day, seven days a week. When the unit's consultant was not on site, they provided a thirty minute response on an on-call basis.
- Access to clinical investigation services was available across the whole week. This included X-rays, magnetic resonance imaging (MRI) scans, computerised tomography (CT or CAT) scans, electroencephalography (EEG) tests to look for signs of epilepsy and echocardiograms (ultrasound heart scans). Endoscopy was available Monday to Friday.

## Access to information

# Critical care

- Patient records were accessible at all times. Care records were carefully ordered and indexed to make access to information easier. Different specialties had specific sections for their notes within care records, making it easier for other teams to find information.
- When a patient was moved out of the unit, for example discharged to another ward, all relevant notes and records required to support their ongoing care travelled with them.
- Test results, for example X-rays and blood tests, were communicated and made available promptly. Tests and results were prioritised, which ensured the most urgent information was available at the earliest opportunity.
- Policies, procedures and other supporting information were readily available when required. The trust's intranet system had a library of policies, procedures and other useful information. Additionally, the unit had a number of task-specific folders available, including safeguarding and Deprivation of Liberty Safeguards.
- There was good awareness of the Deprivation of Liberty Safeguards (DoLS) legislation and process. Staff were able to tell us about the Deprivation of Liberty Safeguards (DoLS) and how they would comply with this legislation. There was a folder with guidance, processes and paperwork for staff to follow and complete. We reviewed the care record of one patient who was subject to a DoLS authorisation and saw the relevant paperwork and decision making records were all completed.
- The unit had a flowchart to be followed when considering possible restraint of a patient. Staff understood the difference between lawful and unlawful restraint. This included a risk assessment for staff, patients and others, and encouraged using the least-restrictive means of managing the patient. Restraint audit forms and hourly monitoring charts were then used and the flowchart reapplied if there were any changes. Staff were aware of the legal issues surrounding restraint and that any restraint used needed to be the least restrictive option.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had good knowledge of the Mental Capacity Act and the importance of obtaining consent and/or acting in a patient's best interests. Procedures and decision making records were available to support staff with these processes, and we saw these were completed comprehensively in all cases. Staff were able to talk to us easily about mental capacity assessments and best interest decisions. Best interest decisions are decisions made by healthcare professionals in the best interest of a patient where they do not have the capacity to make that decision for themselves.
- We were told about one patient in the unit for whom it had been agreed that giving covert medication was appropriate. A discussion had taken place between a critical care doctor, pharmacist and mental health practitioner before this treatment plan was commenced, but this discussion and decision had not been recorded in the patient's care records. We raised this with the nurse caring for the patient who immediately contacted the consultant and the records were updated. The decision to give covert medication had been made in accordance with the trust's medicines and mental capacity policies.

## Are critical care services caring?

Good



We have judged the care given to patients and relatives of critical care services to be good.

People were supported, treated with dignity and respect, and were involved as partners in their care.

Feedback from people we met, including patients and their families, had been positive.

Patients and their family or friends were involved with decision making. They were able to ask questions and raise anxieties and concerns and receive answers and information they could understand.

Staff treated patients with kindness and warmth. The unit was busy, but staff always had time to provide individualised care, 'going the extra mile' so patients could undertake activities or attend events important to them. Staff talked about patients compassionately with knowledge of their circumstances and those of their families.

## Compassionate care

# Critical care

- Results from the NHS Friends and Family Test showed excellent results. The CCU implemented the NHS Friends and Family test in June 2015. Patients were asked to say if they would recommend the unit to their family and friends. In May 2015, 97% of those patients who responded (35 patients) said they would be 'highly likely' or 'likely' to recommend the ward. In June, 100% of those patients who responded (25 patients) said they would be 'highly likely' or 'likely' to recommend the ward.
- Visitors were met by staff as soon as possible. Relatives and friends were usually greeted within 15 minutes of their arrival. During our inspection we saw visitors being greeted promptly when arriving at the unit. However, on occasions when staff were not able to meet relatives promptly, there was an intercom system in the waiting room so the relatives could call through to the unit to be kept informed.
- We were given examples of staff 'going the extra mile' for their patients, including making arrangements for a patient to attend a family wedding in London, accompanied by unit staff. We also observed staff taking the time to accompany patients outside into the hospital grounds.
- Patients' privacy, dignity and confidentiality were not always maintained. We observed two morning ward rounds during which patients were discussed by nursing and medical staff. These discussions took place outside the patients' rooms and could be overheard by patients and visitors in neighbouring rooms because doors were open. While patients were being examined and/or treated, staff always closed the curtains in the room to maintain privacy and dignity for the patient.

## **Understanding and involvement of patients and those close to them**

- Patients and their relatives were involved with care and treatment plans and discussions. One patient told us they had been involved in all stages of their treatment and care, and had been kept informed about being discharged from the unit to another ward in the hospital. One patient's relatives told us they felt included. They told us that staff took the time to talk to both them and the patient, explaining what treatment

and care they were giving to the patient, even when the patient was not conscious. Staff had also taken time to learn some sign language to aid their communication with this patient.

- We observed information about a patient's diagnosis, treatment and care plan being discussed with patients and relatives in an open and supportive manner. Staff took the time to explain in detail what was wrong with a patient and how they would be treated and care for while in the unit.
- The unit was using the Treatment Escalation Plan to record decisions about whether to provide cardiopulmonary resuscitation, where appropriate. The plan also included decisions about the appropriateness of other treatment, for example the administration of intravenous medicines and ventilation, and its use encouraged and recorded patient and relative involvement.
- The unit led on, and participated in, organ donation programmes. The clinical lead for organ donation explained how a specialist nurse for organ donation, either from within the unit or from the specialist nurse team within the south central area, would be involved with all discussions with relatives around organ donation. Family members were given time to understand what organ donation involved and how it could benefit other patients. Families were then enabled to make an informed decision about organ donation and would be supported by the specialist nurse throughout.

## **Emotional support**

- There were some emotional support arrangements in place for patients and their families. The unit was using patient diaries for longer-stay patients. Research has shown how patients sedated and ventilated in critical care suffer memory loss and often experience psychological disturbances post discharge. They have been shown to provide comfort to patients and their relatives, both during the stay and after discharge. Diaries are said to not only fill the memory gap, but also be a caring intervention which can promote holistic nursing.

# Critical care

- The unit was planning to introduce bereavement follow-up phone calls to provide emotional support to families, but these were not in place at the time of our visit and there was no timescale available for when these might be started.
- Staff understood the impact a patient's care, treatment or condition might have on their wellbeing and on those close to them both emotionally and socially. There was good support from the hospital multi-faith chaplaincy team who were on call at all times for patients, their family and friends and also staff.

## Are critical care services responsive?

Good



We have judged the responsiveness of the critical care unit to be good.

Services were planned and delivered to meet the needs of the local population, with comfortable facilities available for patients and visitors. Services were equally accessible for all, and no discrimination (unintended or otherwise) was demonstrated in how services were delivered.

Delays and cancellations as a result of bed unavailability in the unit were minimal; however, there were some discharge delays due to pressures with beds elsewhere in the hospital.

The unit did not receive very many complaints, but there was a clear system in place for the investigation process, including involvement and feedback to patients, relatives and staff.

### Service planning and delivery to meet the needs of local people

- The service had been designed and planned to meet people's needs. The unit was located within the hospital to enable staff to respond to emergencies either within the critical care unit or the operating theatres. The emergency department was, however, located on another floor and not, as recommended by the Department of Health, co-located. Despite issues with access and flow due to bed pressures in the hospital

and elsewhere in the health economy, the unit was responsive to emergency admissions and was very rarely unable to provide a critically unwell patient with a bed and the care and treatment they needed.

- There was good provision of facilities for visitors to the unit. A comfortable and bright waiting room was available just within the entrance to the unit and away from the main clinical area.
- There were two rooms available for visitors to stay in overnight. Visitors had to vacate the room daily so it could be cleaned, but we were told there was no limit to the number of overnight stays. Both rooms had sofa beds and were clean and well presented. A small shower room was available and nearby these overnight rooms; however, this was also for patient use and shared with patients staying overnight in the day surgery unit. The unit had a dedicated consultation room where staff could talk to relatives in a comfortable environment away from the ward.
- Patients shared one toilet in a large room off the main ward. There was a small shower room available but this was located in the corridor near the overnight stay and waiting rooms.
- The CCU had equipment to meet patient's health needs that could be unrelated to their critical illness or condition. This included, for example, haemofiltration machines to provide treatment for patients with kidney failure which might be unrelated to their critical illness.
- The trust's website included a page about the critical care unit. Information included contact details, the role of the unit, visiting arrangements and storage of patient's property.
- Patients in the CCU were cared for in private rooms and this overcame the majority of the rules around gender separation. Department of Health guidance recognised gender separation was difficult to fully manage in units like the CCU. Like many intensive care units nationally the CCU had no provision of separate gender toilets or washing facilities to meet the element of the same-sex rules. The ICNARC data showing four-hour delays in discharge from critical care to a ward bed of around 70% of all patients meant the unit frequently breached the same-sex rules as they related to providing washing facilities and toilets.

# Critical care

- The unit operated a stabilisation before retrieval service for children under the age of 16. Children requiring high dependency or intensive care would receive initial treatment in the unit before a team from a children's specialist hospital arrived to retrieve the patient. In a few cases, children had been admitted to the unit for treatment because it was felt this was safer for them than being treated on the paediatric ward. We were told that a number of nurses on the critical care unit had completed a course for the management of children in an adult setting, with at least one of these nurses being on duty at all times. The numbers of nursing staff who had completed paediatric life support training was low.
- The Core Standards for Intensive Care Units (2013) recommend that patients discharged from intensive care should have access to a follow-up clinic. The unit did not have a funded follow-up clinic but were running an unfunded, ad-hoc clinic to follow-up patients and to return patient diaries to the patient. The unit's review against the Core Standards for Intensive Care Units (2013) reported there was a large unmet need for psychological support for both patients and relatives, with no referral pathways available while the patient was still in hospital. Any psychological support required after discharge had to be arranged by the patient through their GP.
- Patients requiring ventilation following discharge were supported by a home ventilation service. The trust ran a home ventilation service for patients that had been discharged and assessed by respiratory consultants as needing ventilation at home. These patients were issued with a machine to use at home and were followed up at a ventilation clinic. Carers supporting patients on home ventilation were provided training by respiratory nurses.
- Patients' individual circumstances and needs were taken into account and processes put in place to support them in the majority of cases. A discharge services team was available to support those patients who were well enough to be discharged from the unit to a ward, or in very rare cases back home from the CCU. Staff were concerned about one patient in the unit who, although not ready for discharge, did not have a home or other place of safety to be discharged to. The team sought early involvement from discharge services to ensure that when the patient was ready to be discharged, there was a plan in place to and dementia specialist nurses; additionally, dementia and learning disability were subjects taught during the induction process and we saw that staff were able to appropriately respond to these patient's needs.
- Interpreting services were available through an external provider. We were told this was primarily telephone based, but an interpreter could attend if notice was given. The need for interpreter input was very minimal in the unit, with no recent examples of the unit using this service.
- All patients we reviewed had treatment plans with clear timeframes and objectives. We saw documentation was clear and concise. Records contained assessments, diagnoses and plans for treatment with rationalised objectives and achievable timescales for tasks and reviews.
- Patients admitted to the unit were reviewed within 12 hours by an intensivist. Of the eight care records we reviewed, all patients had been reviewed by a consultant intensivist when they were admitted to the unit.
- The unit had an 'activities trolley', which was available to high dependency patients and contained activities including board games, providing both opportunities for stimulation and relaxation.
- Information was readily available to support patients, their relatives and friends. The unit had a printed leaflet for relatives and friends with useful information about the care provided in a critical care unit. It explained the visiting times in the unit, the availability of waiting rooms and accommodation, contacting the unit, and spiritual support. Additionally, there were multiple

## Meeting people's individual needs

- There were no apparent barriers to admission due to a patient's age or gender. The average age for patients admitted to the CCU was 61 years, which was similar to the national average and had been static for much of the past five years. ICNARC data for the three months from January 2015 showed a typical distribution of ages of patients admitted, and the unit, like other similar units, had treated patients in their 80s and early 90s. Not untypically, the majority of patients admitted were male (around 52%).

# Critical care

information leaflets on a wide range of subjects available in the waiting room, including organ, blood and tissue donation, the Patient Advice and Liaison Service, and support for carers.

- Patients were not always given important personal information following tests. A number of patients were screened for HIV where their condition suggested this could be a factor. For example, patients with severe sepsis and pneumonia were routinely screened. Only patients testing positive for HIV were informed the test had been carried out and the result. Those patients whose tests came back negative were not being informed of the test being undertaken or results. There was no intention by staff to withhold information or not be open with patients, but the consequences of not sharing this with the patient had not been given appropriate consideration.

## Access and flow

- The hospital was mostly caring for its own patients (as opposed to admitting them from other hospitals). In the ICNARC data from January to March 2015 there were fewer patients than average transferred into the unit from an HDU or ICU in another hospital.
- Patients were infrequently transferred to other units for clinical reasons. Usually transfers out were for patients to be accommodated closer to home or for specialist care. Transfers had been mostly below (better than) the national average for the last five years. There were two patients transferred out in January to March 2015.
- Processes were in place to ensure beds for elective (planned) surgery patients who were undergoing complex procedures were booked in advance. Bookings were entered into a paper-based diary, which was checked daily and updated with any changes. We were told that no elective surgery had been cancelled in the last six months as a result of the lack of an available bed in critical care.
- Many patient discharges were delayed due to a bed elsewhere in the hospital not being available. This was on the unit's risk register. Similar to most critical care units in England, ICNARC data reported a high level of delayed discharges from the CCU. In the last five years between 60% and 75% of all discharges were delayed by more than four hours from the patient being ready to leave the unit. That was above (worse than) the national

average of around 60%. Four hours was the indicator used for comparison with other units to demonstrate the ability to move patients out of critical care in a timely way. Although patients remained well cared for in critical care, when they were medically fit to be discharged elsewhere, the unit was not the best place for them. It also could delay patients who needed to be admitted or meant the unit was always at higher occupancy than recommended. The delays were, however, mostly less than 24 hours.

- The Core Standards for Intensive Care Units (2013) state all discharges from critical care to a general ward should occur within four hours of the decision being made. The unit's review showed staff were continuing to work towards this and had made some progress in improving discharge times. However, it was acknowledged there was still some way to go and close working with the hospital and community teams to increase the overall flow issues in the hospital were required.
- The discharge of patients from the CCU was not always achieved at the right time for the patient, although, over time, the unit was below (better than) national averages for moving patients at night. Studies have shown discharge at night can increase the risk of mortality; disorientate and cause stress to patients; and be detrimental to the handover of the patient. Data from ICNARC for January to March 2015 for discharges made out-of-hours (between 10pm and 7am) showed the unit had been much the same as the national average for night-time discharge for similar units. In this first quarter of 2015 the out-of-hours discharges were 5% of all discharges (12 from 230 patients) against a national average of 6%. Rates had fluctuated in different quarters but for the last five years had almost always been below the national average.
- The unit had relatively high occupancy levels compared with other units, and often above recommended levels. The Royal College of Anaesthetists recommend a maximum critical care bed occupancy of 70%. Persistent bed occupancy of more than 70% suggests a unit is too small, and 80% or more was likely to result in non-clinical transfers that carry associated risks. The unit's occupancy levels for January to July 2015 were 94% on average. This was against an NHS average for the same period of 85%. Within this average figure for the unit were four months of 100% occupancy, although

# Critical care

the latest published data for July 2015 was 80% against an England average of 83%. The high occupancy levels at this hospital were due to a lack of a ward beds into which to move a discharged patient, and, as with the national picture, an increasing demand for critical care beds which was not meeting rising demand.

## Learning from complaints and concerns

- Processes were in place to ensure complaints were investigated and learning points identified. The unit had only received one recent complaint; in January 2015. The investigation documentation showed learning had been shared not only with the staff directly involved with the incident, but also with the wider departmental team. Complaints were investigated by the relevant line manager, or a nominated deputy, and process actively included any staff involved with the patient's care.
- The Patient Advice and Liaison Service (PALS) was advertised in the waiting room, with leaflets about their services available for relatives to take away. Staff told us that should a patient wish to make a complaint they would attempt to resolve any concerns within the unit first before then involving the PALS team. If the patient was unable to make contact with PALS themselves, or did not wish to discuss their concern with a critical care staff member, a PALS representative could come to the unit and discuss the concerns privately with the patient.

## Are critical care services well-led?

Requires improvement



We have judged the leadership of the critical care services to require improvement.

While we found the leaders in the unit to be committed, there were limited governance arrangements.

The unit had a draft five year strategy, which had not been cited or approved by the directorate. It was not aligned with the trust's five year strategy and did not show how the areas for development and improvement would be achieved, or who was responsible or accountable for the work.

There was no governance structure in the unit, and nobody leading on governance in the consultant team.

Multi-professional clinical governance meeting were not being held monthly.

Meeting minutes had not been regularly kept, although this had been rectified since August 2015. Actions arising from meetings were not monitored effectively.

The unit did not have an audit calendar, and there were limited examples of regular care and safety audits and performance measures being completed and reviewed.

Although views and suggestions from staff and patients were being sought, there was little evidence that these were being used to actively improve services in the unit.

Financial constraints in the trust were limiting the unit's ability to innovate and improve, and the team questioned the sustainability of the unit without investment.

## Vision and strategy for this service

- There was a local vision and strategy document for the critical care unit, but this did not appear in the overarching five year strategy for the directorate. The critical care unit produced a five year strategy document in September 2015, written by the clinical lead. As yet this document had not been submitted to, or reviewed by, the directorate board and only had local oversight.
- Items in the local strategy document included:
  - embedding delirium management;
  - training for echocardiography;
  - a 24 hours a day, seven days a week, outreach service;
  - a new clinical information system;
  - review of paediatric high dependency provision;
  - staff and demand modelling
- None of the areas within the strategy had clear information and ideas about how these developments could, and/or would, be achieved. Staff were aware of the strategy and involved with developing some elements of it but there were no action plans or accountability for delivering the strategy's objectives. The clinical lead for the directorate explained that the unit's five-year strategy was in draft form at this stage and would be presented to the directorate board for consideration in the near future.

## Governance, risk management and quality measurement

# Critical care

- There was a lack of departmental clinical governance. Unit managers recognised governance arrangements in critical care needed improvement. There was a limited governance structure in place and the unit did not have a dedicated governance lead among the consultant team. However, there was a lead consultant for mortality and morbidity. Additionally, in a review of the Core Standards for Intensive Care Units (2013), the unit identified they were not holding multi-professional clinical governance meetings each month.
- Staff said the unit had been holding regular business meetings and advisory groups. There were, however, no minutes for any of the meetings between October 2013 and July 2015. The last two meetings in August and September 2015 had been minuted. The minutes were brief and actions were recorded at the end of each section. There was, however, no evidence to show if actions were taken and whether these had achieved the required improvement.
- The unit participated in a national database for adult critical care as recommended by the Core Standards for Intensive Care Units (2013). The unit contributed data to the Intensive Care National Audit and Research Centre (ICNARC) Case Mix Programme for England, Wales and Northern Ireland. ICNARC reported the data supplied was well completed and of good quality.
- There were limited audits and performance measures of care and safety in accordance with an approved audit calendar. There were few examples of regular audits being completed. For example, there was no evidence of regular auditing of procedures such as cannula care, central venous catheter care, ventilator-associated pneumonia, patient records, or equipment checks. Some useful ad-hoc and specific project-related audits had been completed, for example CT scanning for laparotomy patients, HIV testing and use of capnography in cardiac arrest. The lack of governance minutes meant there was no evidence of how these had been used to improve patient care or demonstrate how care being provided was of a high quality.
- Risk management was not vigorously managed. The unit's risk register contained six entries, of which three items had overdue actions. The risk register was reviewed at the advisory group meetings but minutes of these did not show actions were being discussed, challenged and monitored. There were items identified

through the unit's own projects that had not been entered to the risk register. This included, for example, the decline in the number of nurses in the unit holding critical care awards and where the unit did not fully comply with the Department of Health building specifications.

## Leadership of service

- Nurse managers in the unit had been trained in leadership skills, but lacked the time within their roles to focus on leading and developing the team. All band seven and band eight nursing staff had completed a trust-led leadership course, including a mentoring programme. The trust had also recently implemented a managerial programme for band five and band six staff who were looking to progress into leadership positions.
- The matron had responsibility not only for the critical care unit, but also for another 35 bedded ward. Additionally, they took some leadership responsibilities for the pain team and had responsibility for clinical nurse education. Given they were part time and had these varying responsibilities; they had limited time to dedicate to the unit.
- The leadership team within critical care was supportive, approachable, visible and respected, but staff felt leadership at directorate level was less so. Staff told us they regularly saw their departmental managers in the unit, including undertaking clinical shifts. They said these leaders acknowledged concerns and took action where appropriate. Staff felt comfortable approaching their immediate managers and supported and encouraged to do so. However, staff told us the director responsible for critical care rarely visited the unit or engaged with the staff. Feedback from directorate level in response to concerns raised by critical care staff was minimal, and directorate meeting minutes contained limited detail around critical care.
- The concerns unit managers told us about were in line with the concerns of the critical care team. Managers told us their greatest concerns for the unit were:
  - The gap in outreach services between 4pm and 8am;
  - A lack of administrative support for the unit;
  - An inability to undertake or participate in research due to staffing levels;
  - The lack of a supernumerary nurse in charge;
  - Delayed discharges;

# Critical care

- Skill mix;
- Staff being relocated to other units because of staffing shortages

These concerns mirrored what staff were telling us; some were in the unit's strategy and others were on the risk register.

## Culture within the service

- There was a positive, supportive and open culture in the unit. Staff told us they worked in a supportive team, ensuring everyone was included and felt able to seek support from one another. Staff felt able to talk openly and to approach managers and issues were dealt with fairly and compassionately. One member of staff added "I really like the team support on the unit."
- The trust had welfare arrangements in place for staff, including access to a confidential counselling service, physiotherapy arrangements, bereavement support and occupational health. Additionally, managers told us they would arrange debriefings for staff after particularly difficult cases, and there was access to immediate support from colleagues within the unit.

## Public and staff engagement

- Views from patients, families, carers and friends were sought. The unit had recently started using the NHS







Friends and Family Test (FFT) to understand the views of patients, friends and relatives. Given the nature of the care and treatment undertaken in the unit this was not always the most effective way to engage with people. An in-house questionnaire had therefore recently been developed with more relevance to the unit. Staff hoped this would provide more direct feedback for the unit to use to develop and improve services.

- Staff were encouraged to engage with departmental reviews and make suggestions for service improvements. The critical care unit had recently implemented an 'ideas box' to encourage staff to think about ways of improving services and patient care.

## Innovation, improvement and sustainability

- There was limited focus on innovation and improvement within the unit. Although the unit's strategy focused on areas for investment to ensure improvement and sustainability of services, there were no formalised plans or processes in place to carry this work forward. We were told the trust's financial pressures were being felt in the unit, particularly with regard to agency staffing. This was raising questions among the team about how sustainable the unit was and left uncertainty about the possibility of innovation and improvement ideas actually being taken forward.

# Maternity and gynaecology

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

## Information about the service

Great Western Hospital provided a range of antenatal, perinatal and postnatal maternity services in the hospital and local community settings. Maternity and gynaecology were managed within the Women and Children's division of the trust's services.

There was a consultant led delivery suite at the hospital which provided care for women with high risk and/or complex pregnancies. There were 13 delivery rooms, one room had a birthing pool and all the rooms had en suite showers. There were two admission/triage rooms, each with an assessment couch. There were two dedicated maternity theatres.

There was an adjacent midwifery led unit called the White Horse Birth Centre which opened during 2011. This was accessed through Hazel ward. The unit was equipped to support a home from home, natural birth experience, and was for women assessed as having low risk pregnancies. On the unit, there were two assessment rooms, and four delivery rooms. Two of these rooms had birthing pools and had en suite showers. In addition there was a family room with comfortable seating and a kitchenette area stocked with drinks and snacks. Women who had uncomplicated births on the delivery suite or birth centre were expected to go home from the hospital within six hours of birth.

Between April 2014 and March 2015, 4,480 babies were delivered with support from Great Western Hospital maternity services. From the 1 April 2015 to 30 September 2015 there were a total of 2190 births. Of these, 1740 (79.%)

births were at the consultant led unit and 432 (19%) at the maternity led unit. There were 18 (0.82%) home births which included six born before the arrival of the midwife or arrival at the hospital.

There was a maternity day assessment unit and ultrasound service which enabled pregnancies to be monitored, screening tests to be completed and potential problems diagnosed. These services were accessed on an outpatient basis. Antenatal and postnatal care for women needing to stay longer in the hospital was provided on Hazel ward which had three, four-bedded bays with shared bathroom facilities next to them. There were an additional 18 single en suite rooms (total 30 beds).

There was an early pregnancy/emergency gynaecology two bedded unit next to Beech ward. This included an ultrasound service and examination room which provided treatment and support to women with complications in early pregnancy or with emergency gynaecological problems.

A range of gynaecological investigations and treatments were provided. These included general and emergency gynaecology, urogynaecology, colposcopy, gynaecological cancer and abnormal bleeding. There were approximately 16,000 gynaecology outpatients' appointments per year and 120 gynaecology elective surgeries per month. Many procedures, including minor operations were completed within outpatient's clinics or on the day surgery unit. A termination of pregnancy service was provided. This was for medical terminations for fetal abnormalities up to 20 weeks plus six days of pregnancy. Women who required a medical termination for fetal abnormalities beyond this

# Maternity and gynaecology

date were referred to a specialist service. Women requiring inpatient care for gynaecological or early pregnancy care were admitted to Beech ward which had three four bedded bays and six side rooms (total 18 beds).

During our inspection we spoke with seven patients, four relatives and a range of staff working across the gynaecology and maternity services. These included; the divisional manager, associate medical director, consultant obstetricians, gynaecologists and anaesthetists, registrars, sonographers, the head of midwifery, the two midwifery matrons, consultant nurse for gynaecology, midwives, nurses, health care support workers, maternity support workers, ward clerks and a chaplain. We held a number of focus groups and meetings. One was attended by 12 band five and band six midwives; another was attended by five band seven midwives and one band eight midwife. We had a meeting with seven community midwifery and support staff. We observed a staff handover on the central delivery suite and a multidisciplinary maternity forum which was attended by 17 medical and midwifery staff. We reviewed eight sets of patient records. Before, during, and after our inspection we reviewed the trust's performance information.

## Summary of findings

Overall, we have judged the maternity and gynaecology services to be good for responsive, effective, caring and well-led services. Overall, we have judged safety in the maternity service requires improvement.

Care in both the gynaecology and maternity wards and central delivery suite was consultant led. Patients had risk assessments completed and reviewed regularly. There were established and thorough safeguarding procedures in place. Systems were in place which ensured women who required emergency obstetrics and gynaecology treatment and care were seen promptly by specialist nurses and consultants at all times. Clinical procedures were provided in line with national guidance and policy.

Safety improvements were required to the maternity services. The midwifery staffing levels did not comply with the Health and Social Care Act (2008) Code of Practice on staffing. The midwife to patient ratio exceeded (was worse than) recommended levels and one to one care for women in established labour was not achieved 100% of the time. A midwifery skill mix and staffing ratios paper had been written by the head of midwifery. This had been planned for presentation to the board during August 2015 and included proposals to mitigate risks to patient care resulting from inadequate midwifery staffing. However, the board had delayed this presentation and review of proposed actions until November 2015.

The maternity services were responsive to the needs of local women and those living outside of the locality of the hospital. The majority of patients were satisfied with the care and treatment they received and would recommend services. We saw records documenting patient's choices and preferences. Additional specialist counselling was available to patients as required. Access and flow through the gynaecology inpatient service had been affected by intense trust wide service pressures.

At departmental levels there were effective, risk, quality and governance structures in place. Incidents, audits and other risk and quality measures were reviewed for service improvements and actions taken. Improvements

# Maternity and gynaecology

were required to risk management processes at a senior level to ensure a complete overview of all serious issues and actions was maintained, and escalated to the board.

At departmental levels, systems were in place to effectively share information and learning. There was a positive culture and staff were proud of the patient care they provided and spoke of good and productive team working practices. Consultant, nursing and midwifery leadership was described as good, junior staff were well supported and departmental senior managers were visible and approachable. There was strong evidence from the midwives and consultant obstetricians of innovations completed to improve treatment, care and outcomes for patients.

## Are maternity and gynaecology services safe?

Requires improvement



Overall we have judged safety as requiring improvement. This applied to the maternity services as midwifery staffing levels did not comply with the Health and Social Care Act (2008) Code of Practice on staffing. The midwife to patient ratio exceeded (was worse than) recommended levels and one to one care for women in established labour was not achieved 100% of the time. The trusts maternity and general IT systems were not compatible. This duplicated tasks and necessitated additional written records. This increased the potential for errors.

Gynaecological and maternity records contained clear plans of care, and appropriate referrals to other professions or services. Women had individual risks assessed and these were regularly reviewed. There was evidence of investigating and learning from incidents. Staff were knowledgeable about safeguarding process and understood their responsibilities. There was a high level of consultant support available 24 hours across the gynaecology and maternity services to respond to emergencies and maintain oversight of women with high risks and/or complex health.

### Incidents

- The maternity and gynaecology staff we spoke with said they were encouraged to report incidents and that there was a no blame culture with an emphasis on learning. Maternity staff demonstrated an understanding of what type of issues constituted a reportable incident. These included; third and fourth degree tears, post-partum haemorrhages and unexpected admissions to the neonatal intensive care unit (NICU).
- Staff demonstrated an understanding of the processes to follow and learning from incidents which were reported on the trust's electronic reporting system. Staff told us feedback and learning from incidents was provided in various forms, dependent upon the type and impact on patient care. This was provided on a one to one basis by senior staff and or cascaded through team meetings and staff handovers, and within the monthly newsletter. We looked at a selection of meeting

# Maternity and gynaecology

minutes and monthly maternity staff newsletters. These reported incidents as standard agenda items. This included the rates and types of incidents, changes to policy and specific learning.

- Staff reported the majority of incidents in a timely way. Between July 2014 and June 2015, 783 incidents were reported by the maternity and gynaecology services. The trusts policy (July 2015) stated all incident should be logged promptly with actions completed between 14 and 60 days, depending upon severity. There were gaps between the trusts incident system and uploading the information onto the National Reporting and Learning System (NRLS). The NRLS system showed 61% of incidents were reported and actioned within 14 days, 85% within 30 days and 92% within 90 days.
- The majority of incidents caused no harm to patients. The most frequently reported incident category was linked to a procedure or treatment (300 out of 783). Nearly three quarters of all incidents reported, 74% (586) were assessed as having caused no harm to patients with a further 23% (179) assessed causing a low level of harm. There were 17 incidents that resulted in moderate harm. Most of these (14) were categorised as resulting from issues relating to a procedure or treatment. The three remaining incidents related to access, admission, transfer and booking.
- The trust followed the serious incident framework guidance from the Department of Health (March, 2015). This states an incident must be considered on a case-by-case basis against a revised description of serious issues. There was clear evidence of investigation and learning at departmental levels which was evidenced in root cause analysis investigations and risk and governance meeting minutes. In addition, records showed serious incidents were logged onto the national quality improvement programme 'Each Baby Counts' (2015) Royal College of Obstetricians and Gynaecologists.
- Between May 2014 and April 2015 five serious incidents had been reported, three related to maternity and two to gynaecology. We reviewed the root cause analysis investigation for one of the maternity incidents. Records showed this had been robustly completed by an obstetric consultant, employed externally to Great Western Hospital trust. The investigation made five recommendations and we saw appropriate action plans

and timescales to complete these were in place, including evidence of shared learning widely within the department. We reviewed other records which showed the remaining serious incidents were at various stages of investigation.

- Perinatal mortality and morbidity meetings and gynaecology mortality and morbidity meetings were held every month. We looked at meeting minutes which detailed individual case reviews. Whilst the gynaecology minutes recorded attendees, there were none noted for the maternity meetings. However, for both, discussions between clinical staff regarding improvements to practice and procedures were recorded. For example, in the June 2015 minutes, a discrepancy was noted regarding the scoring of the Apgar test of a newborns physical condition. This test was completed at one and five minutes after birth to evaluate the need for additional medical or emergency care. The actions included reminding staff of the criteria for scores. We saw in the June/July 2015 maternity newsletter that this information had been included.

## Duty of candour

- During November 2014, a new regulation was introduced to providers of NHS patients who were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to incidents termed as 'reportable patient safety incidents'. These were any unintended or unexpected incidents occurring to a patient leading to death, severe, moderate or prolonged psychological harm. This regulation requires staff to be open, transparent and candid with patients and relatives when things had gone wrong. Staff throughout the maternity and gynaecology services demonstrated an understanding of this and what actions needed to be taken when patient treatment or care had gone wrong or had not been satisfactory.
- Records documented conversations with patients relating to duty of candour. We reviewed an initial investigation report following an incident on the delivery suite dated October 2015. This stated the patient was seen by the obstetric consultant who explained the error. The patient had been given an apology and told an investigation would be completed and they would be kept informed of the findings. This issue remained ongoing at the time of our inspection.

# Maternity and gynaecology

## Safety thermometer

- The inpatient maternity and gynaecology wards (Hazel and Beech) participated in the NHS safety thermometer. This was a process to collect patient safety information in relation to falls, catheter associated infections, venous thromboembolism (VTE), urinary tract infections, and pressure sores. Information provided by the trust showed from September 2014 to September 2015 there were no recorded patient harms under these categories.

## Cleanliness, infection control and hygiene

- All ward and clinical areas in the maternity and gynaecology services appeared clean. We observed stickers were used to indicate when equipment had been cleaned and was ready for use.
- The patients we spoke with had no concerns regarding the cleanliness of the environment. Patients confirmed they saw staff washed their hands and wore personal protective clothing such as gloves and aprons before providing treatment or care. Antibacterial hand cleaner was available throughout clinical areas and poster prompts for hand washing were displayed throughout departments. We observed staff washed their hands before and after providing care or treatment to patients.
- Cleaning staff were employed by another organisation who had responsibility for cleaning floors, bathrooms and communal areas. Staff in all areas confirmed the cleaning supervisor regularly checked the standard of cleaning and immediately addressed any concerns.
- Equipment used in central delivery suite and birthing centre was visibly clean. The midwifery care assistants had responsibility for this and cleaned equipment in-between admissions. We saw records of daily cleanliness inspections of the environment and equipment completed by the delivery suite coordinator. In addition, there was a two week rota of deep cleaning tasks. Staff responsibilities for completing these were allocated by the midwifery delivery suite coordinator every day.
- The two birthing pools in the White Horse Birth centre looked visibly clean. These were decontaminated by staff after each use in order to be available for the next person using the room. The one birthing pool in the central delivery suite looked visibly clean.
- Monthly infection control and hand hygiene audits were completed by the gynaecology and maternity services. We reviewed records dated from March 2015 to August 2015 for the central delivery suite, birthing centre, emergency gynaecology/early pregnancy service and Hazel and Beech wards. The data showed the majority scored 100% compliance with infection prevention and control standards. Where there were dips in compliance, improvements were documented in the following months.
- There was a low risk of obstetric post-operative infection. Records provided by the trust showed between October 2014 and December 2014, 3% (9 out of 280) of women who had a caesarean section contracted a post-operative infection. This was lower than the England national average of 9%.
- There was variable compliance with infection prevention and control training. Information supplied by the trust dated July 2015 showed an overall compliance rate across both maternity and gynaecology services of 77%, which was slightly below the trusts target of 80%. Data for infection prevention and control training for obstetrics and gynaecology medical staff was 38%. We spoke to the associate medical director regarding this and they showed us actions they were taking to ensure the medical staff were booked onto update training sessions.

## Environment and equipment

- The delivery suite environment was well organised, with equipment stored appropriately.
- The maternity and gynaecology wards were accessible with a swipe card for staff and controlled by a buzzer for patients and visitors. CCTV was used by ward clerks, clinical staff and security staff to monitor for unauthorised access to the delivery suite and wards. There were effective back up plans. Midwives told us of one occasion when the electronic system developed a fault. Trust security staff sat at the entrance to the delivery suite until the situation was resolved.
- An electronic tagging system was used with babies born in the delivery suite. This had to be processed by a midwife before safe discharge from the unit. On the White Horse Birth centre and Hazel ward, there were no nurseries and women kept their babies in cots next to their beds at all times.

# Maternity and gynaecology

- On the central delivery suite, there were 12 delivery rooms, one room had a birthing pool and all the rooms had en suite showers. There were two maternity theatres and two admission rooms, each had an assessment couch. All areas were appropriate for use.
- Plans were in place to relocate and upgrade the room with a birth pool to be more consistent with the 'homely' facilities on the White Horse Birth centre. This coincided with work planned for a two roomed bereavement suite. Staff told us this work was planned to be completed by the end of the year.
- The central delivery suite had adult and baby emergency resuscitation equipment. Baby resuscitaires and cardiotochograph equipment for fetal heart monitoring were in each delivery room. Daily safety checks of this equipment were documented.
- We saw some equipment did not have in date maintenance checks on Hazel ward and the central delivery suite. For example, four sonicaid doppler's (for checking the fetal heartrate) last service dates were April 2014, August 2014 and October 2013.
- The White Horse Birth centre was equipped to support a home from home, natural birth experience. There were two assessment rooms, and four delivery rooms. Two of these rooms had birthing pools and all had had en suite showers. Each room had birth couches and a range of equipment to aid labour and birth. These included ceiling mounted slings, birthing stools and balls. There was adult and baby emergency resuscitation equipment and a baby resuscitaires. Daily safety checks of this equipment were documented.
- Hazel ward had 30 beds and took a combination of ante and post-natal patients, and provided care for some babies meeting the criteria of transistion care (babies requiring extra treatment, care or observations). There was adult and baby emergency resuscitation equipment and a baby resuscitaire. Daily safety checks of this equipment were documented.
- There was an early pregnancy/emergency gynaecology two bedded unit next to Beech ward. This included ultrasound equipment and an examination room. Beech ward had three four bedded bays and six side rooms

(total 18 beds) for inpatient gynaecological or early pregnancy care. There was adult emergency resuscitation equipment which records showed were checked daily and all areas were appropriate for use.

## Medicines

- Medicines and controlled drugs were stored safely. We observed medicines in appropriately locked cupboards, and within the resuscitation trolleys, in the maternity theatres and other clinical areas. Midwives and nurses told us they had adequate stocks of medicines and no issues with the pharmacy services.
- Oxygen and nitrous oxide (used for pain relief) was piped into delivery rooms. Records showed the maintenance of these gases were reviewed and monitored. Stronger analgesia was available for women in labour if they required it.
- Medicines that required storage at low temperatures were kept in dedicated fridges in locked rooms accessible only by staff. Records showed fridge temperatures were checked daily.

## Records

- The trusts maternity IT system was not fully compatible with the trusts general IT system. Midwives told us it was therefore necessary to log in and out of the two systems to fully record patient information. Additional written records were maintained to ensure up to date patient information was more easily accessible. These complex records system increased the potential for errors. Staff throughout the hospital's maternity services said these systems duplicated work, were confusing and time consuming.
- Gynaecology and midwifery medical records and other confidential patient information was stored safely in lockable records trolleys. These were accessible to all staff who required access to them.
- We reviewed eight gynaecological and maternity patient records and the maternity safeguarding files. These records demonstrated clear plans of care. However, the maternity records were complicated in places due to the different IT printouts. Referrals to other professions or services had been made where necessary and information shared appropriately.

# Maternity and gynaecology

- Pregnant women had hand held records which were provided at their initial booking of ante natal care and maintained through to completion of post-natal care by community midwives. We saw all necessary risk assessments were completed and regularly reviewed. Risks were recorded as having been discussed with patients. The way the records were used, enabled clinicians to have the most up to date and relevant information when reviewing care.
- Systems were in place which ensured the legal requirements of a termination of pregnancy were followed and documented in records. Processes were followed which ensured the required records were properly completed and forwarded to the Department of Health in a timely way. Stickers were used on records to indicate when specific parts of the process had been completed. This followed good practice guidance recommended by the Royal College of Obstetricians and Gynaecologists (2011).

## Safeguarding

- Staff we spoke with were knowledgeable about the trust's safeguarding process and were clear about their responsibilities. Staff demonstrated an understanding of what kind of issues might alert them to consider issues, and what they could do to respond to the patient in a safe and supportive manner. We looked at records which showed when concerns had been identified, appropriate referrals had been made and these were fully documented.
- Women were assessed for mental health issues as part of antenatal, perinatal and post-natal care. There was a midwife who specialised in working with vulnerable adults including those with mental health needs. If issues were identified records showed, appropriate support was provided. Consent was sought to make referrals and share information with other professionals involved with their care.
- Mandatory safeguarding and vulnerable adults training had been completed by obstetrics and gynaecology staff. Records dated July 2015 showed the majority of staff were compliant with this and training was booked for those still requiring it.
- Obstetrics and gynaecology staff attended one of three levels of mandatory safeguarding children training, dependent upon their role. Records dated July 2015

showed the majority (95-100%) of non-medical staff had in date level one safeguarding children training. The overall compliance with level two training was 81%. Compliance with level three safeguarding training was 36% which was significantly below the trusts acceptance level of 80%. However, other records showed plans were in place to address this, with staff booked on training

- The lead midwife for safeguarding was trained to the advanced level four in safeguarding and protecting vulnerable adults. This person provided advice and support to staff when required. This included specific safeguarding supervision which was provided to midwives who were involved in safeguarding procedures. We saw this documented in records.
- Medical staff did not achieve the trusts expectations of 80% across all three safeguarding children's mandatory training levels. Records showed 77% obstetrics and gynaecology doctors were trained at level one, 69% at level two and 34% at level three. We spoke to the associate medical director regarding this and they showed us actions they were taking to ensure the medical staff were booked onto update training sessions.

## Mandatory training

- The trust provided a range of statutory and mandatory training for staff which were allocated based on roles. The trust set a compliance target of 80% which records dated July 2015, showed was not fully met by the obstetrics and gynaecology staff. This included training on dementia which was 79%; slips, trips and falls, 78% and information governance and record keeping updates, 63%. Senior staff told us these issues were in the process of being addressed.
- Maternity staff attended an additional day's mandatory skills and drills prompt training (practical emergency obstetric training). We looked at records which showed a high level of compliance by midwives. During the past 18 months compliance ranged from 92% and 100%, the reductions were due to staff maternity leave. Less medical staff were compliant, 74% had in date skills and drills training from August 2014 to August 2015 but had

# Maternity and gynaecology

been booked onto update sessions. Midwives spoke positively about the quality of this training and the use of a simulation model which was used to recreate emergency scenarios.

- All midwives were trained in Neonatal Advanced Life Support as required by the UK Resuscitation Council and attended annual update training.

## Assessing and responding to patient risk

- All pregnant women had comprehensive risk assessments which were started at the first booking appointment and reviewed with every subsequent contact with a midwife. This included screening for pre-eclampsia, gestational diabetes, venous thromboembolism, female genital mutilation and medical conditions. Other risk factors were also assessed and discussed with women including; previous obstetric history, social issues, and screening for domestic abuse and mental health issues. Women who presented in labour unknown to the service were considered as high risk and provided care in the central delivery suite.
- The central delivery suite was consultant led and able to support women with high risk pregnancies and/or complex health. There were consultant obstetric leads for antenatal and intrapartum high risk care. Women who wished to deliver at the adjacent midwife led birth centre were assessed against a strict criterion. For example, the woman had to have no ante natal complications and spontaneous onset of labour at no less than 37 weeks and no more than term plus 13 days.
- Women assessed as having low risks who attended the birth centre who developed unexpected complications were transferred immediately to the nearby consultant led delivery suite on the same floor. Transfer rates were consistent. Between January and March 2015 records showed the average transfer rate was 23% and between April 2015 and June 2015, 21%.
- Systems were in place to respond to acute, severe and unpredictable obstetric emergencies. Anaesthetic and obstetric medical staff were available 24 hours a day, seven days per week by a dedicated on call rota. Staff on these rotas included specialist medical trainees and consultants in anaesthetics and obstetrics, trainee GPs and an anaesthetic assistant. On call consultant obstetricians and anaesthetists were contractually obliged to be on site within 30 minutes of the call. We observed on call contact information was available on the central delivery suite and with the hospitals main switchboard staff. Midwives told us the consultants responded promptly to emergencies.
- Consultants and midwives were familiar with guidelines for the emergency management of a cord prolapse and post-partum haemorrhage. We saw records which showed emergency skills' training was completed annually by medical and maternity staff.
- On admission, when high risk or complex pregnancies were identified, treatment management plans were further reviewed with the patient and agreed between the obstetric, paediatric and/or anaesthetic consultants involved.
- The consultant paediatricians reviewed the admission board on a daily basis with the delivery suite coordinator to ensure the special care baby unit were aware of potential transfers to their department.
- On the central delivery suite, each room had cardiotachograph equipment for fetal heart monitoring. We observed 'fresh eyes' stickers had been signed to confirm trace readings had been double checked by a second midwife. These actions ensured any additional concerns or actions could be promptly responded to.
- Safe practice guidance was followed before obstetric surgery commenced. We saw the World Health Organisation (WHO) surgical safety checklist was completed as required. This guidance prompted actions for safe clinical practice before anaesthesia, before incisions, and before the patient left the operating room. We reviewed six months of audit records to review compliance with the WHO checklist. During each month, 130 records were checked against four standards. Between January 2015 and March 2015 overall compliance ranged from 82% to 98%. We saw actions were put in place to improve standards. Between April 2015 and June 2015 the overall compliance had increased to 99% for one standard and 100% for the remaining three standards.
- Obstetric risk management guidance tools were available, used and appropriately referenced to other national standards and guidance. For example; we saw

# Maternity and gynaecology

records of risk assessments for venous thromboembolism, safe induction of labour, and risk assessments of women who had had previous caesarean section.

- Staff demonstrated an understanding of gynaecology emergency risk management guidelines, and knew where and how to access these for reference. Guidelines were based on national best practice standards and guidance. For example, National Institute for Health and Care Excellence (NICE) clinical guidance 154 on the management of ectopic pregnancy and miscarriage.
- Hazel ward (post-natal and transitional care) was next to the special care baby and staff said in event of a paediatric emergency, staff from this unit were available to assist within minutes.

## Midwifery staffing

- There were 132.85 whole time equivalent (WTE) midwives supporting the provision of maternity and obstetric services within the trust and local community. This included one WTE head of midwifery, two WTE clinical midwifery managers (matrons), a risk management and governance midwife, an audit midwife, a safeguarding midwife, an infant feeding specialist midwife, a mental health and addiction specialist midwife, 1.6 WTE screening specialist midwives, and a practice development midwife. There were no vacancies, the midwifery staff were working to their full establishment.
- There were inadequate numbers of midwives to meet the Royal College of Obstetricians and Gynaecologists (RCOG, 2007) Safer Childbirth Minimum Standards for the Organisation and Delivery of Care in Labour. This recommends a midwife to patient ratio of 1:28 for safe capacity to achieve one-to-one care in labour. One to one care was defined at the hospital as necessary during established labour and for two hours following birth (delivery suite coordinators meeting minutes 1 April 2015). We looked at records which showed during July 2014, the ratio was 1:32, during December 2014, 1:43 and from May 2015 to September 2015, 1:37.
- We reviewed one to one audit information for a 6 month period dated to 1 April 2015 to 30 September 2015 during which time there were 2190 births. Analysis of this showed one to one care was not achieved 100% of the time as recommended.
- On the consultant led delivery suite, there were 1740 births of which 71% (1239) of women received one to one care.
- On the adjacent midwife led birth centre, there were 423 births, of which 77% (331) of women received one to one care
- There were 11 planned home births of which 100% of women received one to one care. There were six babies born before arrival to hospital or arrival of a midwife of which 33% (two) did not receive one to one care.
- This did not comply with the Health and Social Care Act (2008) Code of Practice on staffing.
- Shortfalls in midwifery staffing were covered from substantive midwives temporarily increasing their hours. If staffing issues were not resolved this way, the maternity escalation policy was followed. This required the community and ward midwives, and if required, the specialist midwives and midwifery matron to be redeployed to fill any staffing gaps. No maternity agency staff were used. Senior midwives confirmed the escalation policy had to be used most days, and they were concerned about staffing levels. We saw records which showed this information was entered on the risk register.
- The maternity staff had devised a 'Red Flag' checklist based on NICE safer staffing guidelines (2015). This was a list of events that indicated there may not have been enough midwives to fully provide care. The checklist was used to review acuity and provision of the care and treatment needs of women and babies using the service each day. For example, the red flags included delays completing observations, administration of medicines and of essential care including nutrition, hydration, and comfort needs. At the time of our inspection, the checklist had only been used for a few months and had not been evaluated. However, senior staff told us the checklist was referenced to on a daily basis in conjunction with the maternity escalation policy.
- The community midwives faced significant impacts from insufficient substantive midwifery posts. The community midwives recommended caseload providing ante and post-natal care was 1:100 (Birthrate Plus, Royal College of Midwives) but the case load for the trust locality was 1: 150. We spoke with five community midwives and the community matron who told us they their work was further impacted by the

# Maternity and gynaecology

recurrent use of the escalation policy. This meant the community midwives were frequently redeployed to work within the hospital. In addition each community midwife told us there had been at least one occasion in the last year when this had resulted in them being on duty for 24 hours. This may have increased risks to patient care. As midwifery staffing were filled to the established numbers, there were no additional plans in place to address these issues.

## Medical staffing

- There were safe levels of medical staffing. The trust had 25 whole time equivalent medical staff who worked across the gynaecology and obstetrics services. There were eight consultants who provided 60 hours of obstetrics cover per week. This met the recommendations of the RCOG Safer Childbirth, The Future Workforce (2007).
- More medical staff were employed at consultant and middle grade (at least three years at senior house officer grade or above) compared to the England average figures. No junior medical staff worked in the maternity and gynaecology service and there were less Registrar posts compared to the England average.
- There were sufficient anaesthetic, obstetrics and gynaecology medical staff to provide surgical and clinical support to the maternity and gynaecology services at all times. This was managed through a dedicated on call rota.

## Other staffing

- Senior staff said there were sufficient staff employed in roles which supported the midwifery and gynaecology services. These included a scrub nurse and anaesthetic support worker, sonographers, ward clerks, and care assistants. There were 12.49 band three and 23.56 band two maternity support workers. The physiotherapy team (managed elsewhere) also provided a responsive service to patients on Beech ward.

## Major incident awareness and training

- Senior staff demonstrated an awareness of the trusts major incident plan and how to access this, but had not been included in training. Senior midwives were aware which part of the maternity department had been designated for use and by whom in the event of a major incident.

## Are maternity and gynaecology services effective?

Good



Overall, we have judged effectiveness as good in the maternity and gynaecology services. Policies and guidelines had been developed in line with national policy. These were available on the trusts intranet and staff demonstrated they knew how to access them. A range of equipment and medicines were available to provide pain relief in labour. The midwifery services had achieved full accreditation with UNICEF UK breast feeding standards. There was evidence of good communication between professions and specialities. Systems were in place which ensured women who required emergency obstetrics and gynaecology care were seen promptly by specialist nurses and consultants at all times. Elective, gynaecology treatment was frequently delayed due to high numbers of other patients admitted to the ward. Team working in both services was described as effective and good.

## Evidence-based care and treatment

- We observed policies and guidelines in the maternity and gynaecology services had been developed in line with national policy. These included a range of National Institute for Health and Care Excellence (NICE) guidelines, the Royal College of Obstetricians and Gynaecologist (RCOG); Safer Childbirth (2007), The Care of Women Requesting Induced Abortion (RCOG) and the Termination of Pregnancy for Fetal Abnormality (DoH, 2010) guidance.
- Policies and procedures were available on the trusts intranet and staff demonstrated they knew how to access them. New or updated trust guidance was communicated to staff via meetings and email. We observed policy and procedure updates were included in meeting minutes and the monthly maternity newsletter.
- Maternity care was provided in line with RCOG guidelines minimum standards for the organisation and delivery of care in labour, this included staff roles and

# Maternity and gynaecology

equipment. Processes and procedures followed by staff showed women received care in line with NICE quality standards 22 (for routine antenatal care), 32 (caesarean section) and 37 (postnatal care).

- The termination of pregnancy service was provided in line with RCOG (2011) evidence based clinical guidance and standards. These included a pathway of assessment, treatment and support before, during and after procedures.
- The gynaecology and maternity services had a comprehensive audit programme. This included local clinical audits and participation in national clinical audit. These enable services to evaluate if treatment and care was being provided in line with national standards and to identify improvement actions.
- There was an audit midwife who was responsible for maintaining and contributing to the annual maternity audit plan. There were 21 maternity specific audits dated from January 2014 at various stages of progress and planning. Approximately half of these had additional re audit dates planned in advance. We reviewed one audit report of vaginal tears acquired during delivery. This provided an analysis of the hospital's data and practice, review of national standards and a literature review. Learning from this audit was shared with staff and further actions identified.
- There were six gynaecology specific audits dated from July 2014 at various stages of progress and planning. For example, audit of the management of women diagnosed as having a missed miscarriage. This was linked to the recommendations of NICE clinical guidance 154.
- A specialist midwifery role had recently been extended to include two days per week dedicated to providing specialist support to women with mental health issues. This was as a direct result of NICE quality standards 192 for the clinical management of antenatal and postnatal mental health.

## Pain relief

- Patients we spoke with on both Hazel ward (ante and post-natal) and Beech ward (gynaecology) told us they regularly had their pain assessed by staff and were given medicines promptly. We looked at patient care records and saw pain and comfort needs had been assessed.
- A range of pain relief was available on demand in the delivery unit. A birthing pool was available to relieve and manage pain in labour. Each room had an electronic delivery bed which could be adjusted to support different positions and ease pain in labour and delivery. Nitrous oxide gas (Entonox) and oxygen were piped into each delivery room. Epidurals were available for women in labour 24 hours a day, seven days a week if required. Midwives confirmed anaesthetist's responded promptly.
- In the White Horse Birth unit a range of resources were available to relieve pain and support a natural delivery. Water was used to alleviate pain in labour and birthing pools were available in two of the four delivery rooms. A range of equipment was available in each of the birth rooms to relieve and manage pain in labour. This included, ceiling mounted slings, couches, bean bags, birthing stools and balls. In addition, nitrous oxide gas and oxygen was piped into each room and women were provided pethidine for pain relief. Women were transferred from the birth unit to the delivery suite if they chose to have an epidural for pain relief.
- Pain relief options were planned in advance and with patients on the delivery suite and birth centre. We observed birthing plans had been completed in advance of delivery. This included discussions regarding pain management.
- Midwives told us pain management choices and options were regularly reviewed during labour. We saw this was documented in care records. We saw pain relief information leaflets were available throughout the maternity department.

## Nutrition and hydration

- The maternity services had full accreditation (level 3) with the UNICEF UK Baby Friendly Initiative. This meant staff had fully implemented breast feeding standards which had been externally assessed by UNICEF. This assessment involved interviewing mothers about the care they had received and reviewing policies, guidance and internal audits.

# Maternity and gynaecology

- There was an infant feeding specialist midwife who provided advice and support to patients and staff with all aspects of baby feeding. For example, we saw breast guidance and practice standards updates were included in the maternity monthly newsletter dated June/July 2015.
- We spoke with one patient who told us about the difficulties she had experienced establishing breast feeding with her new baby. She said staff had been attentive, knowledgeably and supportive. The patient said she was reassured and less anxious as result of this.
- Patients told us they were offered plenty of hot and cold drinks and water jugs were frequently refreshed. Snacks and drinks were available to purchase 24 hours a day in between set meal times. On Hazel ward (ante and post-natal) there was a kitchenette area where women and their partners could access hot and cold drinks and snacks when required.
- On the midwifery birthing unit, snack bags were made up every day for women. These included sandwiches, snacks and drinks. The unit had a large day room for use by women and their partners. This included a kitchenette areas to make hot and cold drinks and simple snacks.

## Patient outcomes

- On the consultant delivery suite from the 1 April 2015 to 30 September 2015 there were 1740 (79% of total) births. We reviewed national statistics for the period January 2014 to December 2014 (published May 2015, Hospital Episode Statistics). These showed there were slightly less births by emergency caesarean section; 13% compared to 15% England average. There was a higher rate of instrumental deliveries at the hospital; 10.6% compared to 7.1% England average.
- On the maternity led unit from the 1 April 2015 to 30 September 2015 there were 432 (20% of total) normal, spontaneous deliveries. There were 18 (0.82%) home births which included six born before the arrival of the midwife or arrival at the hospital.
- Women were encouraged to breastfeed following best practice guidance. The uptake of breastfeeding at the hospital exceeded (was better than) the national average. The average rate of breastfeeding from birth was 74.3% (NHS England, July, 2015). Records showed between April 2015 and June 2015 the uptake of breastfeeding by women supported by the hospital maternity services was 78.9%.
- Treatment and care was provided in timely care way. All babies were required to have a neonatal examination within 72 hours of birth. These were performed by paediatricians. In addition 42 midwives had completed specialist training to provide the newborn checks. This enabled checks to be provided in the hospital or community and supported the prevention of discharge delays.
- The majority of transfers from the midwifery led birth centre to the consultant led unit were for unexpected reasons. We looked at data from January 2015 to July 2015. The percentage of intrapartum and post-natal transfers ranged from 17% to 30%, average; 24%. The reasons for transfer included, increased risks identified on admission, raised blood pressure, failure to progress, retained placenta, fetal distress or request for epidural.
- The rate of elective caesarean sections was slightly lower than the England average. Elective sections were booked Monday to Friday, excluding bank holidays, according to the clinical priority of each woman.
- The maternity dashboard was part of a larger south west dashboard which collated performance data for all the maternity services in the region. Agreement on the specifics was still being agreed and the rates of unexpected maternal readmissions to the post-natal ward had been suspended. We reviewed information that was available dated from April 2014 to September 2014. The numbers of maternal readmissions to the post-natal ward were between five and nine per month.
- There was a consistent and low rate of unexpected maternal readmissions to high dependency care in the hospital. Between March 2014 and April 2015 this totalled nine. Care records showed patients and risks were regularly reviewed. Staff were responsive to changing clinical needs, escalating patient concerns promptly.
- There were 2.4 stillbirths per 1,000 births during the period April 2014 to March 2015 compared to the England and Wales average of 4.7 stillbirths per 1,000 births. From April 2015 to date results showed a rate of 3.1 stillbirths per 1,000 births.

# Maternity and gynaecology

- Women with high risk and/or complex pregnancies were supported to maximise positive outcomes. The consultant outpatient's clinics had been reorganised to provide focused, specialist care and treatment to maximise and improve patient outcomes. This included care for women expecting twins or triplets, women with diabetes, epilepsy or heart problems. This enabled more consistent and organised care through the maternity care pathway. These systems had since been copied by other maternity services.
  - The midwives initiated an audit, followed by interdepartmental training to improve and support clinical outcomes for pre-term babies born at the hospital. The prevention of cerebral palsy in pre-term labour (PRCePT) project was linked to a south west initiative intended to create a gold standard of evidenced based care. This may be used at a later date to contribute to the development of national standards. The project focused on enhancing the use of magnesium sulphate with pregnant women at risk of pre-term birth. Audit information showed at the start of the project the use of magnesium was 29.7%. Following information sharing and training to the obstetric and paediatric medical teams, and all midwives, the use of magnesium increased to 100%.
  - The gynaecology service provided comprehensive care for women with a wide range of gynaecology conditions. This included gynaecological cancers, reproductive medicine and a rapid access service for women with abnormal symptoms such as post-menopausal bleeding. Effective systems were in place to provide services to meet patient demand. Between April 2014 and March 2015 16,000 gynaecological outpatient appointments were provided to women in the locality. On average 120 gynaecological operations were performed per month. Specialist consultants were available for particularly sensitive or complex clinical work and there was 24 hour emergency consultant surgical and clinical support available.
- Competent staff**
- Clinical expertise and support was available to midwives on the delivery suite. An experienced, band 7 midwife coordinator was rostered on each shift. When possible, this was supported by a second experienced band 7 or band 6 midwife. These roles provided additional clinical expertise to more junior midwives. An experienced band 6 midwife was rostered on each shift at the adjacent birth centre.
  - Not all staff were being supported to have an annual appraisal. Records dated July 2015 showed between 79% and 100% of appraisals had been completed for administration, midwives, nursing and care assistant staff on the gynaecology ward (Hazel) and ante/postnatal ward (Beech). However, the same records showed midwives and care assistants who worked in the community, and midwives who worked in the birthing centre had between 47% and 67% of in date annual appraisals. This was below the trusts target of 80%. Senior staff assured us appraisals were being scheduled.
  - The ratio of supervisors to midwives (SoM) did not meet recommended guidelines. The regulation of midwives includes an additional layer of investigative and supervisory responsibilities provided by a supervisor of midwives (SoM). By law midwives must have a named SoM with whom they meet once a year to consider their practice. The recommended ratio of SoM to midwives was 1:15 (Midwifery Rules and Standards, rule 12, Nursing and Midwifery Council, 2014). There were nine SoM which gave a ratio at was 1:21. However, one SoM was on extended leave and three additional midwives were close to completing the SoM training (September 2015). It was anticipated the ratio would then reduce to 1: 16.
  - There was a SoM available on call 24 hours a day, seven days per week to support midwives with clinical practice issues. Midwives confirmed supervisors were responsive when contacted for advice.
  - The SoM were required to complete an annual review to provide assurance that midwives were meeting the Nursing and Midwifery Council (NMC) requirements for midwifery practice. The annual local supervision authority report dated February 2015 noted 85% of midwives had completed an annual review. In response, an annual strategy and work plan for annual supervisions had been developed and put in place.
  - There were a number of experienced specialist midwives who had completed additional training in specialised areas of clinical practice. This included

# Maternity and gynaecology

substance misuse, mental health and infectious diseases, practice development, infant feeding, risk management, diabetes and bereavement support. These midwives had lead roles for their specialties, providing clinical updates, audit information and advice and support.

- The consultant nurse gynaecology has specialist skills and knowledge and was available to provide clinical support and advice to junior nurses. Other senior gynaecology nurses had completed specialist training and worked as advanced nurse practitioners. These nurses managed their own clinics providing for example; colposcopy and hysteroscopy treatments.
- Three of the senior nurses (including the consultant nurse) who worked in the early pregnancy and emergency gynaecology service had completed additional nurse prescribing qualifications training. Other advanced training had been completed including post graduate diplomas and master's degrees. This enabled the team to provide competent and effective clinical care and support to patients. In addition, this expertise was disseminated to junior doctors and other staff.
- Hazel ward provided antenatal, post-natal or transitional treatment care. Midwives told us the bays were deliberately mixed, admitting patients from each of the three specialties of clinical need. Midwives told us this ensured practice skills were maintained across the three specialty areas.
- The practice development midwife told us other training was provided on an ad hoc basis in response to identified update training needs. Records showed for example, epidural, suture and breastfeeding update training sessions had been provided. These sessions were facilitated by hospital staff or external, visiting consultants.
- Systems were in place to ensure junior midwives had the required skills for practice. Newly qualified band 5 midwives completed a preceptorship programme during the first year in post. This was to enhance confidence and competence to provide safe, effective care to patients. Once competencies had been fully reviewed and signed off, these midwives progressed to

band 6 posts with increased independent working and responsibilities. This practice followed the recommendations in the Preceptorship Framework (Department of Health, 2010).

- The band six midwives rotated where they worked approximately every three months between the consultant-led delivery suite and Beech ward (ante, transitional and postnatal care). The midwifery matron said this ensured midwives developed and maintained a range of skills. This also enabled midwives to be redeployed to areas with the greatest clinical need.

## Multidisciplinary working

- A consultant led multidisciplinary handover meeting took place every morning and evening on the central delivery suite. This ensured all staff were aware of the treatment and care plans of women requiring obstetric input. We observed a morning meeting. This was attended by consultant obstetricians and anaesthetists, registrars, a range of senior and junior midwives and theatre staff. During the meeting the clinical needs of patients booked for induction and /or elective caesarean sections were reviewed. Staff discussed issues arising from recent safety and policy updates. Staff were allocated roles and responsibilities. All staff engaged and contributed to discussions, which were productive and well managed. A register, signed by all attendees and meeting minutes were maintained. The midwife delivery suite coordinator said the minutes were referred to by staff throughout the shift to ensure all duties and responsibilities were followed thorough. We looked at previous handover meeting minutes which were similar in content.
- There was effective multidisciplinary working between departments. The delivery suite coordinators met with the consultant paediatrician or neonatal intensive care coordinator every morning. Information was shared regarding clinical activity on the delivery suite and availability on the special care baby unit. Schedules were then coordinated to ensure specialist staff were available when required.
- The paediatric, maternity and obstetric staff on Hazel ward worked collaboratively together. Hazel ward provided transitional care to babies who required extra treatment, care or observations. Staff told us specialist support and advice was available promptly if required.

# Maternity and gynaecology

- Staff were proud of multidisciplinary team working practice. All grades and specialities of staff throughout the obstetrics and gynaecology services that we spoke were very positive about multidisciplinary working. Communication and professional support was described as good and excellent. Staff told us they felt part of productive teams who worked cohesively for the benefit of patients.
- The weekly elective caesarean section lists were provided by a dedicated surgical team. The team worked effectively with maternity staff to coordinate and manage surgical procedures. For example, when emergency sections had to be accommodated and the surgical lists had to be revised. Surgical staff attended and contributed to the morning multidisciplinary hand over meetings.
- The midwives worked effectively with services in the community. Antenatal and postnatal care was offered in the woman's home or GP surgery. Information was shared in order to improve outcomes and ensure consistency of care.
- Postnatal care in the community was coordinated effectively. The community administrator had systems in place to keep the community midwives updated. These processes ensured clinical information was shared in a timely way. For example, sonography, test results and delivery and discharge information. This supported a seamless transition of care from the acute to the community setting.

## Seven-day services

- Obstetrics and gynaecology services were consultant lead and provided 24 hour emergency clinical and surgical care, seven days per week
- The central delivery suite and adjacent midwife led unit were staffed 24 hours a day, seven days per week. The maternity services had not closed from January 2014 to September 2015.
- The early pregnancy/emergency gynaecology two bedded unit next to Beech ward was open 24 hours a day, seven days a week. This provided treatment and support to women with complications in early pregnancy or with emergency gynaecological problems.
- The maternity day assessment and ultrasound unit was open from 7.30 am to 8.15 pm every day except

Christmas day. This was used for the monitoring of pregnancy and diagnosis of potential problems. An out of hours imaging was provided by the early pregnancy/emergency gynaecology service or by the hospitals main imaging department.

## Access to information

- Medical records were accessible and available for both gynaecology and maternity clinics. Reception staff told us previous medical records were requested and were supplied before a clinic, and all record requests were checked before clinics started which ensured staff had the information they needed.
- Pregnant women carried their own records which were provided when booking in. These were used by all clinicians involved with care during the pregnancy. After delivery, new records were made which included relevant information regarding the pregnancy, birth and baby. These records were carried by women and used for post-natal care.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff followed the correct processes to gain consent. The seven patients we spoke with all confirmed that staff had asked for permission before proceeding with any care or treatment.
- Procedures to gain consent were documented. The eight care records we reviewed clearly documented discussions regarding consent before carrying out any examination or procedure.
- Staff on Beech ward (gynaecology) said if they had concerns regarding a patient's mental capacity an assessment tool was used. This tool was also used with patients aged 75 years and over, who were admitted as an emergency. We saw this checklist provided prompts to review for symptoms of confusion or delirium. Actions to take were identified including review for other medical conditions and liaison with the patient's GP. Medical staff were required to complete a written summary in care records if the patient was deemed unable to give informed consent and Mental Capacity Act guidance was then followed.
- Not all staff were in date with trusts mandatory training on consent, the Mental Capacity Act 2005 and Deprivation of Liberty safeguards. The trusts minimum

# Maternity and gynaecology

compliance target was 80%. Records for July 2015 showed the average percentage of staff in obstetrics and gynaecology services with this training in date was 74%. Senior staff told us staff were currently being booked onto update training sessions.

## Are maternity and gynaecology services caring?

Good



Overall, we have judged caring in the maternity and gynaecology services as good. Patients told us they felt had their wishes respected, and understood options for care and treatment. Patients and their relatives said they felt involved with care and treatment. Midwives and doctors cared for pregnant women before, during and after birth with kindness, compassion, dignity and respect. Specialist counselling and support was available to women pre and postnatally.

### Compassionate care

- Compassionate and sensitive care was provided to families who had experienced the loss of a baby. Staff provided personalised memory boxes, containing mementoes for bereaved parents. These had been developed in conjunction with the Stillbirth and neonatal death (SANDS charity). Specialist bereavement midwives worked across the maternity and paediatric service providing care and support to families when required.
- Pastoral care by the hospitals chaplain was described by both gynaecology nurses and midwives as very caring and supportive. We spoke with the chaplain who was responding to a patient request on Beech ward. The chaplain told us when asked to attend they prepared for this whenever possible beforehand. For example, by speaking to senior staff and by reading case notes. The chaplain said this enabled them to understand the individual situation and be responsive to needs.
- Systems were in place to provide considerate support to women who miscarried. The Early Pregnancy Assessment Centre liaised every day with the

community administrator. This ensured the community midwives were kept informed in a timely way regarding women who had miscarried. Home visits were then arranged to provide additional support and advice.

- The monthly Friends and Family Test results for inpatient care on the Beech (gynaecology) and Hazel (ante and post-natal) wards was consistently positive. We saw the Friends and Family Test information displayed for August 2015 Beech ward. A total of 271 patients had provided feedback. Overall, 96% were positive about their experience of care, the majority of whom (214) said they would be extremely likely to recommend the service. We reviewed feedback on maternity care, provided directly to us and through the NHS website regarding. The majority (13 out of 16) of the feedback and comments were positive.
- We observed compassionate, dignified and person-centred care was provided to patients. We saw staff knocked on doors before entering rooms. When care was being provided, curtains were used to cover windows in the doors and protect patients' privacy and dignity.
- We observed recent letters and cards from patients expressing grateful thanks for the care received throughout all the gynaecology and maternity services.

### Understanding and involvement of patients and those close to them

- Women had a choice of place of delivery dependent upon a comprehensive risk assessment of needs, which was regularly reviewed. Options included a home birth, attendance at the adjacent midwifery unit (White Horse birth centre) or at the consultant led central delivery suite.
- Most of the patients on the gynaecology and maternity services we spoke with told us they felt involved in their care, and information had been presented in meaningful and understandable ways. Patients said they were encouraged to ask questions and when possible, had been given time to consider information before making decisions. We spoke with four partners of women who told us they felt included and given explanations of care as it was occurring which they had found reassuring.

# Maternity and gynaecology

- Staff demonstrated a familiarity with how patients preferred to receive their care. Regardless of this understanding, we heard when staff wished to provide care, they explained what they would like to do and why. Ward areas were relaxed and staff had developed friendly but respectful relationships with both patients and relatives.
- During July 2015 the trusts patient advice and liaison service (PALS) completed a maternity survey to analyse and understand patients' experiences and involvement in care (Picker survey). Questionnaires were sent to a sample of 300 patients, of which 122 were returned (41%). Responses were compared with the average scores for all other maternity trusts who had contributed to the same survey. An interim report had been provided. This showed where feedback scored significantly better or worse. The results showed the maternity service scored significantly higher for treating patients with respect and dignity, being spoken to in way which was understood and always receiving help by staff when needed. There were three negative areas identified. This included lack of choice for antenatal care, not being able to see the same midwife postnatally and dissatisfaction with the length of hospital stay. Action plans had been made pending the full results and report due at a later date.

## Emotional support

- The specialist midwives provided counselling and support to women undergoing antenatal screening. Staff said women who attended for termination of pregnancy for fetal abnormalities were allocated a side room to increase privacy. Partners were supported and able to stay for extended visiting and overnight.
- We observed emotional support provided to patients. We heard midwives supporting women on the telephone and in clinical areas. Individual concerns were promptly identified and responded to in reassuring and positive ways. Patients were spoken with in an unhurried manner, midwives checked if information was understood. When speaking on the telephone, women were encouraged to call back at any time if they continued to have concerns, however minor they perceived them to be.
- A bereavement midwife supported families in the event of a pregnancy loss or still birth. Information was

provided to enable patients and their relatives to understand processes and options available. This included funeral services. Additional emotional support was available if required through the chaplaincy services.

- The consultants provided a specialist pre and post pregnancy counselling service. This included emotional support and counselling for women with pre-existing conditions such as cardio-respiratory disease and previous treatment for malignancy. Post pregnancy counselling was provided for issues such as stillbirth or traumatic delivery and for women who had needed to be admitted to intensive care during pregnancy, or following delivery. Referrals to this clinic were accepted from other specialties or from the community midwives or a patient's GP.

## Are maternity and gynaecology services responsive?

Good



Overall, we have judged responsiveness in the maternity and gynaecology services as good. Systems were in place to plan services to meet the needs of local people. Access to the maternity service was efficient and responsive. There was evidence staff across services strived to be responsive to individual needs. There was a range of written information and resources. Systems were in place to monitor and learn from complaints. Access and flow through the gynaecology inpatient service was affected by in response to intense trust wide service pressures.

## Service planning and delivery to meet the needs of local people

- Systems were in place to plan maternity care to meet the needs of local people. Senior midwifery staff attended the south west strategic clinical network maternity working group. Meetings were held every two months and were attended by clinicians and managers of acute trusts in the region, commissioners of maternity services, patient representatives and Public Health England. The purpose of the group was to develop quality standards and benchmarking tools that took account of the needs of the local population. We looked at meeting minutes for March 2015 and May 2015. The

# Maternity and gynaecology

minutes documented how the group took account of local health needs. For example, how to effectively monitor the number of women smoking at the time of booking and the development of a still birth care bundle toolkit. Whilst no meetings were held during the summer months, the next meeting was planned for November 2015.

- The facilities and premises were appropriate for the delivery of maternity and gynaecology services. Two areas on the central delivery suite had plans in place to improve how patient care was delivered and received. This included the development of a two roomed bereavement suite and refurbishment of the delivery room with the birth pool. Staff told us this work was anticipated to be completed by the end of the year.
- The community midwives (employed by the trust) provided care in community venues to suit individual needs. This included at patient's homes or at their GP practice. The delivery of care in GP surgeries provided additional opportunities to engage with local people.
- For women whose first language was not English; maternity information was provided in other languages. Staff said an interpreting telephone system was used regularly to support women in the hospital and community.

## Access and flow

- The maternity services responded to the needs of pregnant women living in the locality who required care, treatment and support before, during and after birth. Between April 2014 and March 2015, 4,480 babies were delivered supported by the maternity services at Great Western Hospital. From the 01 April 2015 to 30 September 2015 there were a total of 2190 births.
- Access and flow through the gynaecology inpatient service had been affected by intense trust wide service pressures. We reviewed records dated September 2014 to August 2015. Between 44 and 64 gynaecology specific elective surgeries were scheduled per month (total 646, average 53.8). Between one and 13 of these surgeries were cancelled on the day surgery (total 81, average 6.75). Whilst the reasons recorded for cancellation included not enough theatre time or insufficient theatre staff, just over half (41) were due to no bed available for the gynaecology patient.
- A maternity triage service was provided through the maternity day assessment unit and central delivery suite 24 hours a day, all year round. This enabled pregnant women to call or visit with concerns or queries. This service supported effective flow through to the different maternity services.
- Between January 2014 and September 2015, the maternity services had not closed and were responsive to the needs of women living within and outside of the locality of the hospital. The head of midwifery told us every month women living well out of the area requested to be accepted for maternity care at the hospital. Cases were reviewed and accepted on individual basis and only with support from the woman's local community midwifery service. When other maternity hospitals (Reading and Oxford) had needed to close, they had been redirected to, and accepted at Great Western maternity services.
- Midwives and gynaecology nurses had completed additional training which supported the flow of patients through the department. Three senior gynaecology nurses had completed additional nurse prescribing qualifications training and 42 midwives were trained to provide newborn checks. Staff said this enabled treatments to be provided promptly and prevented discharge delays.
- Discharge from the postnatal ward (Hazel) was coordinated and efficient. Women had an individual breast feeding consultation and provided with all their discharge advice or information. Group discharge sessions were provided when possible. We observed systems were in place which ensured discharge summary information was effectively communicated to GPs and community midwives. This promoted continuity of care.
- Systems were in place which ensured women who required emergency obstetrics and gynaecology care were seen promptly by specialist nurses and consultants. The early pregnancy and emergency gynaecology unit (EPU/EGU) provided 24 hour care and treatment. This specialist service protected the trusts emergency department (ED) from a large cohort of emergency patients. We observed a protocol in place for redirecting patients who presented at ED to the EPU/

# Maternity and gynaecology

EGU. We spoke with clinical staff from both services and they demonstrated a clear understanding of processes and were able to give examples of using the protocol in practice.

- Beech ward (gynaecology) was being consistently used to accommodate patients from other specialties. This was in response to ongoing pressures within the medical and surgical departments. Staff told us the impact of this was gynaecology admissions for planned treatment and care were delayed (see responsive section). We reviewed records dated March 2015 to August 2015 and saw the percentage of gynaecology patients on Beech was consistently below 50% of the total numbers of patient's on the ward. Figures ranged from 36.5% (May 2015) to 48.7% (March 2015).
- We met with the clinical site manager for the hospital on during the unannounced part of the inspection. We were told nine medical patients from the emergency department were to be admitted to Beech ward. This would have impacted on the planned gynaecology intake for the following day.

## Meeting people's individual needs

- The maternity and gynaecology staff were responsive to individual needs. Patients told us staff provided personalised care and treatment. We spoke with seven patients and four partners. We were told staff checked with patients how they preferred to receive their care.
- One patient who had left the gynaecology service, returned specifically to speak with us. This person received treatment and care for a long term condition requiring numerous appointments. Staff had been flexible to this patient's specific needs, accommodating appointments specifically around the patients other commitments. This patient was extremely grateful for this, stating it had enabled her to continue to learn how to manage her condition independently and this had also increased her confidence.
- New mothers told us they had birth plans and midwives had followed these as much as possible without compromising safety. We saw these discussions documented in care plans.
- Women were supported to have a personalised birth experience if their baby needed to be delivered in theatre. Women having a non-emergency caesarean section birth were able to have a partner with them in theatre for support and bring their own music which was played during the delivery. Partners were able to film the birth in theatre if they wished.
- Midwives explained how they supported women with complex or specific needs at all stages of the maternity pathway. For example, one woman who had a learning disability was supported to familiarise herself with the environment and procedures in advance of admission. This supported a reduction in anxieties. Consideration was taken to ensure information was provided in a format the patient understood and at their own pace. In another example, we were told how a woman and her partner were supported with their faith and cultural needs. This included a blessing ceremony provided by the chaplain prior to discharge.
- The hospital maternity website was clear and easy to navigate, with text and videos. Hyperlinks to other information such as the baby friendly initiative worked well. There was clear information regarding issues such as length of stay, partners staying and contact details to all the maternity departments.
- Single en suite rooms were available to request for post-natal care. Partners were also able to also stay for extended periods or overnight in relaxer chairs. These were subject to availability and a charge of £175.00
- Translation services were available. The midwives were familiar with, and used, a telephone translation service which was prompt and effective.
- The consultant nurse assured us gynaecology patients' were offered, and provided with a chaperone for appointments if required.
- The delivery suite had plans in place to refurbish two rooms for bereaved parents in order to improve how care was provided. It was anticipated this work would be completed by the end of the year (2015). The service had worked with the charity SANDS to ensure the bereavement suite would appropriately meet the needs of families. The suite was to be soundproofed and enabled parents to stay together and have extended family visit in privacy.
- The trust provided a termination of pregnancy service. Information was provided on choices for fetal remains and counselling was provided as or when required.

# Maternity and gynaecology

- We saw a range of leaflets and information on conditions, treatments and medicines were available throughout the maternity and gynaecology departments. These were available in alternative languages. When discharged from the delivery suite or wards, women were provided with an information booklet. This gave advice and support and for post-natal and baby care and health. For example, contraception services and care of the umbilical cord.

## Learning from complaints and concerns

- Complaints were reviewed by the head of midwifery, the midwifery matrons and the consultant gynaecology nurse. We saw complaints were investigated, actions recorded and learning identified as part of clinical governance meeting minutes. Learning points were disseminated more widely during staff meetings and the monthly maternity newsletter.
- We saw a portion of maternity complaints were as a result of care and delivery not received according to personalised birth plans. We reviewed these complaints. The majority of these were due to risks escalating or emergencies. Senior midwives told us as a result they were planning to introduce a birth afterthoughts service. This would be facilitated by a midwife and provide women and their partners the opportunity to discuss, review and understand their personal experiences in more detail.
- The maternity services had looked for ways to learn and make improvements from other maternity services. The head of midwifery, consultant obstetrician and clinical risk and audit midwives had completed a service gap analysis in response to issues identified in Morecambe Bay maternity services investigation (DoH, 2015). The group had reviewed Great Western Hospital's maternity service provision against the five key learning points in the report. Whilst no significant gaps in compliance were established, actions were put in place to improve quality and risk standards. For example, updating specific guidelines and training sessions in line with 2015 NICE clinical guidance and a review of the antenatal outpatient area to establish a dedicated counselling room.

## Are maternity and gynaecology services well-led?

Good



Overall we considered well led as good for the maternity and governance services. At departmental levels, there were effective, risk, quality and governance structures in place. There was evidence to show incidents and other risk and quality measures were interrogated for service improvements and responsive actions taken. However, improvements were required to risk management processes at a senior level to ensure the trust had a complete overview of all serious incidents, and for effective interdepartmental learning.

At departmental levels, systems were in place to share information and learning. There was a positive culture and staff were proud of the care they provided and spoke of good team working practices. There was strong evidence of innovations to improve care and treatment for patients.

## Vision and strategy for this service

- Both the gynaecology and maternity had service line strategies in place, which senior staff had developed and understood. Midwives demonstrated a broad understanding of the maternity vision and strategy and of the trusts core values. All the midwives we spoke with stated their goal was to provide high quality, person centre midwifery care.
- Systems were in place to develop a unified vision and approach to maternity care across the south west region. Senior midwives attended the south west strategic clinical network, maternity working group. Meetings were facilitated every two months. The aim to this group was to develop a cohesive approach to maternity practice across the south west area. Meeting minutes documented discussions regarding national initiatives and policies, and subsequent actions to incorporate new practice and policies at a local level. For example, meeting minutes documented the group had received a presentation on the Royal College of Obstetricians and Gynaecologists, 'Every Baby Counts' programme. The minutes recorded subsequent discussions and analysis using local case examples. Information and learning was disseminated within the maternity services. We saw reference to the 'Every Baby Counts' programme actions documented in other governance and audit meetings.

# Maternity and gynaecology

## Governance, risk management and quality measurement

- Senior staff within the gynaecology and midwifery services demonstrated an understanding of current service risks. We looked at how incidents and risks were identified, recorded and mitigated. We spoke with senior midwives who demonstrated an awareness of what issues had been currently reported and subsequent actions planned to reduce further risks.
- We looked at a range of departmental meeting minutes. These included the monthly maternity risk management and clinical governance meetings, community midwifery team meetings, the trust monthly senior nurse team meeting. We saw governance, risk management and quality information was shared and actions followed. For example, additional medicines the community midwives would be required to carry, safe storage of these and related policy updates. This was in response to ambulance staff no longer providing medicines used during labour and delivery. We observed maternity policies and procedures were in date and ratified.
- We reviewed the quarterly maternity risk management and clinical governance records for the last two quarters and saw that summaries of the perinatal mortality and morbidity meetings were further discussed and evaluated for potential risk and quality improvements.
- There was a governance process in place which midwifery and gynaecology staff understood, enabling information to be escalated. There were gaps in the quality and risk measurement systems which were in place to monitor and review serious incidents. The trust followed the serious incident framework guidance from the Department of Health (March, 2015). This states the severity of an incident must be considered on a case-by-case basis, with no definitive list for what constituted a serious incident. Records showed incidents were appropriately reported and investigated at departmental levels. The trust had a process in place for all incidents to be screened by the clinical risk team. Not all of the team had a clinical background. Incidents our clinical experts felt were serious had passed through this checking process unchallenged, such as for example, an intrapartum stillbirth. Maternity staff reported incidents to the national quality improvement programme (Royal College of Obstetricians and Gynaecologists (RCOG), 2015). However, the same incidents deemed serious by the RCOG were not reported to the divisional governance committee. This meant the number of maternity incidents presented to the trust's governance committee and board may have been underrepresented. Therefore risk and quality improvement opportunities may have been missed, such as shared interdepartmental learning. In addition, the trust could not be assured they always had a complete overview of the full number of serious incidents within the maternity department. We spoke with the trust's deputy director of quality governance regarding these issues during our inspection. They agreed the current system required improvements and would investigate this further.
- All the maternity staff we spoke with from the divisional manager and associate medical director through to all grades of midwifery staff, raised concerns regarding midwifery staffing levels which were above (worse than) the recommended levels (RCOG, 2007). The service was working to its full establishment, and the escalation policy had been used most days. Staffing pressures had become apparent following the transfer of one acute maternity service and five community maternity services to an alternative provider in June 2014. We observed midwifery staffing levels had been recorded on the risk register. However, there were no action plans in place to mitigate the consequences of increased risks and other service impacts on patient care. There was long term reliance on the good will of midwives to take additional roles and work additional hours. The head of midwifery and divisional manager confirmed they had raised these issues with the board. No subsequent actions had been taken as the maternity service was regarded as continuing to provide a safe, effective and responsive service. A midwifery skill mix and staffing ratios paper had been written by the head of midwifery. This had been due to be presented to the board during August 2015. However, the board had delayed this review, and consideration of actions to improve the midwifery staffing levels until November 2015.
- The patient risk midwife, supported by the audit midwife, was responsible for the majority of governance and quality measures. This person had assumed responsibility from the head of midwifery and consultant obstetric lead for risk, for providing guidance

# Maternity and gynaecology

and support on day to day risk related issues. The risk midwife was not available during our inspection. We spoke with the inpatient matron and audit midwife who demonstrated a clear oversight of all current issues.

- Risk, governance and quality information was interrogated for service and safety improvements. We observed there were thorough documentation, action plans and audit trails in place. For example, audit evaluations of midwifery record keeping showed processes required improvements. In response, we saw improved guidance for the analysis and rating of record keeping. We saw this guidance had been subsequently used by midwives to complete self or peer review as part of supervision processes.

## Leadership of service

- The consultant obstetrician, gynaecologist and anaesthetists provided good leadership and support to junior medical staff. We spoke with junior doctors who said they had excellent support and working relationships with the consultants. The doctors told us they got the right balance of training opportunities and responsibility and they felt encouraged and nurtured by senior staff.
- There was consistent satisfaction with the quality of training and support provided to GPs and specialist trainees by the consultant obstetricians and gynaecologists. We saw correspondence from the local General Medical Council (GMC) GP educator team dated July 2015. This congratulated the consultants for achieving excellent survey feedback from trainees. Reported particularly positively was the quality of handovers and teaching.
- Senior midwifery and gynaecology staff were visible and present in clinical areas and demonstrated a good understanding of current clinical activity and priorities on the days of our inspection. The senior maternity staff aimed, and mostly achieved working one clinical shift per month. This was done to maintain clinical practice, support other staff and to strengthen leadership skills. The consultant nurse regularly worked clinical shifts.

## Culture within the service

- All the gynaecology and maternity staff we spoke with overwhelmingly enjoyed working with their colleagues and were proud of the care they provided. Staff said there was a friendly and effective team working culture.
- Staff demonstrated good communication skills and team working practices. We observed staff were freely able to give their opinions, which were listened to by others and valued. Staff were professional and relaxed in each other's company.

## Public and staff engagement

- Staff were kept updated on, and encouraged to provide ideas or contribute to the monthly maternity newsletters. Other information relating to the trust or gynaecology and maternity services were disseminated in emails and staff meetings.
- There were monthly labour ward and community forums. These provided opportunities for staff to ask questions on any areas of the service. We attended a labour ward forum and saw staff were at ease and able to contribute to discussions. We looked at previous labour and community forums which were well attended by staff.
- Patients staying within the gynaecology and maternity services were encouraged to complete the Friends and Family test. Patients we spoke with told us they had been provided forms to complete prior to leaving the hospital.

## Innovation, improvement and sustainability

- One midwife at the hospital had won the regional award for Midwife of the Year, 2014. This was part of The Royal College of Midwives (RCM) annual midwifery awards. The midwife was nominated by the parents of stillborn baby for the exceptional care and support provided during a difficult labour and birth.
- There was evidence of innovative practice. The senior consultant obstetrician gynaecologist had won a prestigious award from the All-Party Parliamentary Group during 2011. This was for the development of antenatal clinics to manage high risk pregnancies. This innovation has since been copied by other trusts maternity services.
- The senior consultant obstetrician gynaecologist had recently published a book regarding the management of

# Maternity and gynaecology







high risk pregnancies (Oxford University Press, July 2015). This followed NICE and RCOG guidelines and included care pathways, fact files and patient information.

- The sonographers worked flexibly to support junior medical staff to develop their skills. This included teaching and competency assessments to enable doctors to work with increased independence. These sessions were planned to fit around the doctors other clinical commitments. The sonographers also provided a training course for midwives. Eight midwives had been trained to perform basic sonography techniques to assist with their clinical antenatal and diagnostic duties.
- The gynaecology service had identified future succession planning was required. The consultant nurse specialist was aware which nurses planned to retire in

the near future and the subsequent service impacts. In response, plans and actions were being put in place. This included looking at ways to upskill nurses, including specialist training, to be competent to undertake new roles and responsibility in advance of future vacancies.

- The long term use of Beech (gynaecology) ward for other medical and surgical patients had impacted on the retention and recruitment of skilled gynaecology nurses. There was a lack of opportunity to use and continue to develop their specialist gynaecology training and skills. Nurses on Beech ward had to care for women with diverse medical needs. During June 2015, these issues were presented to part of the trust board meeting. No subsequent actions had been taken.

# Services for children and young people

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

## Information about the service

The Great Western Hospital provides services for children and young people living in Swindon and Wiltshire. In patient services are provided for children and young people of up to 18 years of age with medical, surgical, ear nose and throat, ophthalmology, dermatology and orthopaedic conditions. The hospital ward also provides care for children with complex and chronic illnesses, many of whom require investigative or day care treatment.

The children's unit which provides care for children and young people consists of a general ward, Paediatric Assessment Unit, a local neonatal (level two) unit known as special care baby unit (SCBU) and an outpatient department although children and young people are cared for in other areas of the hospital depending upon their needs. The Shalbourne Suite is a ward for patients who are privately funded. It is located in a separate part of the hospital and children above 12 years of age can receive care as day cases in this area.

The general paediatric ward has 20 beds that were arranged in three, four-bedded bays and eight cubicles during our inspection. Two additional cubicles could be used for further admissions or as high dependency rooms for children if staffing levels allowed. The ward provides facilities that enable parents to stay with their child overnight. The ward also has a schoolroom with teaching staff that allow children to receive education during their hospital stays.

The Paediatric Assessment Unit (PAU) is adjacent to the general ward and was opened in 2014. It provides rapid access for GP referrals for children and young people to gain urgent advice from paediatricians without having to attend the hospital's emergency department.

The Special Care Baby Unit (SCBU) provides care and treatment for babies who are born prematurely, have difficult deliveries or are the subjects of other antenatal concerns. The unit has 18 special care cots, including six high dependency cots and four intensive care cots. Parents are encouraged to assist with their babies' care whenever possible. Additional SCBU facilities include a playroom for siblings, a breastfeeding and expressing area, a parents' sitting room and accommodation in which parents can sleep.

A children's outreach nursing service is also based at the children's unit. The service provides nursing support for children living across Swindon and Wiltshire.

Children were also cared for in other areas of the hospital when they needed to undergo surgery and in the area where dental surgery was undertaken.

We spoke with 74 staff members, including nurses, consultants, medical staff, managers and support staff during our inspection. We also spoke with 19 parents and six children and young people. We visited all paediatric areas as well as areas in which related facilities were shared with adult services. We observed care and examined care records and other documents in all inspected areas.

# Services for children and young people

The Great Western Hospital admitted 5,072 children and young people to the children's unit between January and December 2014. 93.6% of admissions were emergency admissions, 4.7% were day cases and 1.7% were elective.

## Summary of findings

Staff at the Great Western Hospital provided effective and responsive planned and emergency care to children and young people and their families.

People who used the services told us that they felt safe, although we found evidence that there was some risk in staffing levels on the ward and in SCBU. Staffing levels were often below recommended levels on the children's ward and SCBU. Children were cared for alongside adults and able to witness adult behaviour that may be distressing to a child or young person.

Staff at all levels were caring, supportive and keen to do the best job they could.

We found the services to be well led at a local level. Staff felt able to raise issues with local management and felt they were listened to and understood, but not all staff felt engaged with or knew the identities of senior trust executives.

The outreach nursing team provided a caring and effective multidisciplinary and multiagency service for children and young people who required assessment, support and intervention to ensure their wellbeing and development.

# Services for children and young people

## Are services for children and young people safe?

Requires improvement



Overall we found the services that keep children and young people free from harm to require improvement.

There was a lower level of reporting incidents than the national average. Staff reported incidents, received feedback and shared learning. Staff were engaged with preventative measures to reduce the spread of infection. Support with safeguarding of children and young people was available and encouraged but compliance with safeguarding training was poor with some grades of staff.

Staffing requirements on SCBU or the paediatric ward were not calculated using a recognised acuity tool to determine how many staff were required to care for their patients. At the time of our visit there were adequate numbers of staff on duty to care for the patients being cared for. If SCBU and the ward were to reach their full capacity of patients the rostered staff would be insufficient in number to safely care for the patients. Nurses were available from the hospital bank system to fill any shortfalls in staff.

Neonatal Early Warning Score (NEWS) charts were photocopied in black and white only as photocopy anything in colour as said to be too costly. NEWS charts rely on colour to easily identify when a child's condition was deteriorating and being in black and white reduced the clarity of when to escalate a child's deterioration.

Compliance with level three safeguarding children training was 53%, significantly below the trust's target of 80%.

Provision for out-of-hours care by tier one medical staff was inadequate according to medical guidelines. Out of hours, one junior doctor provided cover to the paediatric ward, labour ward, SCBU and the emergency department which would be a risk if more than one department needed their support at any one time.

Patient records could be stored securely and accessibly in available facilities but staff did not always follow the relevant processes. Staff did not always follow the process

for auditing fridge and freezer temperatures on SCBU and there was a lack of recorded actions taken when temperatures went outside the acceptable ranges. Some aspects of hygiene were addressed at the time of our visit.

Records we examined showed that staff had not always recorded medicine audits accurately.

Children and young people were cared for in other areas of the hospital that were not specifically for children. Children were at risk of witnessing adult responses to recovery from surgery with no trained paediatric nurses available in these areas. Staffing was such within the day surgery unit that when the nurse allocated to the area collected patients from the theatre recovery room, children were left in the care of their parent. Surgery for children was performed as part of a general list. The anaesthetist for the lists might have been paediatric trained but this was not a certainty.

Learning was shared from the reviews of child deaths were managed at multiagency meetings with the local safeguarding board. There were also joint morbidity and mortality meetings between the neonatal and maternity departments.

## Incidents

- All staff we spoke with demonstrated knowledge of the reporting system. Many stated they had used the system and received feedback on the resulting actions or investigations.
- Six incidents were reported to the national reporting and learning system for children and young people's services during the previous 12 months. Of these, two incidents took over 90 days to be reported
- The children and young people's service held monthly risk management meetings, attended by a range of staff involved in the care of children including doctors, nurses, divisional managers and staff educators. Staff gave us examples of actions that had been taken to reduce the risk of untoward incidents reoccurring and how patient safety had been improved. For example, SCBU had reported an incident involving patient monitoring equipment used to indicate a sudden deterioration of the infant's condition. This equipment did not have alarms to immediately draw attention to the infant's condition and was particularly relevant to infants who were nursed in cubicles. The incident report had prompted the trust to purchase equipment with

# Services for children and young people

alarms and the infants we saw being nursed in cubicles were monitored using the new equipment. SCBU staff had also introduced a process for medicine charts to be checked by both staff at each handover time. We observed this practice although there was no place on the infants' notes to record that the checks had taken place.

- Mortality and morbidity meetings were held for the babies in the perinatal period to review circumstances of serious illness and death in neonates. Learning was shared at the acute children's services risk management meetings which were held monthly. As an example, a previous incident involving neonatal jaundice was discussed and NICE guidance for the treatment of this condition was implemented by the trust. There were no meetings of this kind convened for older babies and children. As an alternative, a consultant paediatrician attended the multi-agency child death overview panel which was held every three months with the local safeguarding board. Any learning from these meetings was brought back to the trust and discussed at safeguarding meetings as well as shared learning at junior doctors' sessions.
- Duty of Candour legislation has been in place since November 2014 and requires an organisation to disclose and investigate mistakes and offer an apology if the mistake results in a death, severe or moderate level of harm. Since August 2015, duty of candour training had been made a mandatory requirement for all staff to complete. It was included in the induction training for new staff and monitored using a tracking system for existing staff. Staff had either completed or were aware they needed to complete the training. Those staff who had completed the training could describe the process of being open and honest with patients and relatives.
- SCBU provided a room for use by new mothers who wanted to express breast milk using breast pumps provided by the trust. They appeared not to have been cleaned between mothers' use and no cleaning schedule was available. Staff were unclear who was responsible for the hygiene of the pumps. We raised it as a concern and on our next visit to the unit there was a cleaning schedule attached to the pumps and they looked clean.
- Mothers were able to express breast milk and keep it fresh for use by storing it in a fridge or freezer both of which were situated in a room on SCBU. Staff told us they informed parents and provided leaflets with information about how long milk could be safely kept in either the fridge or freezer. Not all mothers were aware of this information and there were no guidelines attached to the equipment.
- Single side rooms were used to reduce the risk of cross-infection. This was for occasions when children or young people had a poor immune system or were potentially suffering from or had an infectious condition. Protective equipment such as aprons and gloves were readily available where they were required.
- We saw parents and children using hand sanitiser appropriately. SCBU staff had a process of teaching hand cleansing techniques to parents when they first visited the unit. The teaching was documented in the patient's record and staff gave a leaflet to parents as a reminder. Parents from the ward area told us they did not get instruction from the staff on admission of their child but followed the instructions which were on the hand sanitising units. The units were available on entry to the ward area and at each patient's bed.
- The trust had a procedure to undertake monthly infection prevention and control audits which assessed staff compliance with activities to help to keep people free from infection. The activities included observing staff using hand sanitiser, dating when dressings were last changed, disposing of sharps safely, staff compliance with required dress code and equipment cleanliness. Audit results recorded between April to August 2015 showed compliance between 93.3% and 100%.
- The trust target for compliance was 95%. Where the compliance score was below 100% the specific reasons

## Cleanliness, infection control and hygiene

- In all areas we visited, we observed staff at all levels washing their hands and using hand sanitiser according to the trust's policy. There were sufficient hand-washing sinks and hand gel dispensers in each area. All the ward and department areas we visited looked clean and tidy and individual cleaning schedules were being maintained including those for toys provided for children to play with during the time they spent at the hospital. We observed the appropriate use of personal protective equipment such as aprons and gloves.

# Services for children and young people

were identified. For example 'dressing not dated'. Compliance had improved to 100% in August 2015. SCBU were compliant for the months the audit was completed but there were some missing results for May and August 2015. The audit results were discussed at monthly meetings of the infection prevention and control committee. Actions were identified and monitored at these meetings. The meeting minutes of 22 September 2015 identified that SCBU had consistently good results for their infection control audits but the link nurses were not returning the audits in a timely manner. Information was cascaded to staff at department and ward meetings.

- There was no incidence of *Clostridium difficile* or methicillin-resistant *Staphylococcus aureus* (MRSA) on any of the children's units, for the period between April to August 2015.
- In March 2015 the trust completed a risk assessment of areas that may be at risk of harbouring *Pseudomonas aeruginosa*, a naturally occurring organism in water courses and damp environments. Its presence may cause a risk to patients who have a reduced immune system. The protocol of testing at regular intervals was followed ensuring infants remained safe from the risk of infection. The taps in SCBU were clear of the organism but as an extra precaution the unit manager had a filter placed on the tap that parents accessed for water to bathe their infants.

## Environment and equipment

- The children's ward, SCBU and children's outpatient department were suitable for the ages of children they cared for. The ward consisted of bays with four beds or cots. Single side rooms had private bathroom facilities. There was an assessment unit adjacent to the ward separated into bays with a variety of beds and chairs where children and their parents could wait to see a paediatric doctor either for routine blood tests or further assessment of their condition. In all of these areas there were safe areas for children to play, teenagers had a separate room away from the bed space which had a high door handle to prevent young children entering unsupervised. Television and electronic games were available for their entertainment. SCBU had a total of 18 cots including the intensive care bay, special care bay or a single cubicle depending upon the needs of the infant. Children's outpatients had a play area away from the

main door and each consulting room contained equipment suitable for a child including a small number of toys. There were facilities for the adults to sit near to their child until they were called for their appointment.

- The main door to the children's ward remained locked until a member of staff released it for people who wanted to either enter or leave the ward. Staff could view who was at the door by viewing the closed circuit television screen located at the reception desk. When the receptionist was unavailable other ward staff would operate the door release.
- Equipment, such as hoists, for use with children who had limited mobility had been maintained and were ready for use.
- A system was in place to ensure essential electrical equipment had a constant power supply in the event of a general power outage. The plugs of the equipment were also brightly coloured to reduce the risk of accidental removal of the plug from its power source.
- SCBU had a fridge and freezer for mothers to store breast milk for later use. There was a system for staff to check the temperatures daily and record the result on a log sheet attached to the equipment. Staff described the process that if the fridge was outside of the temperature range of between two and six degrees centigrade, it should be recorded in the ward diary and reported to the maintenance department. On two occasions in September the log indicated temperatures outside of these parameters but the diary had no entry for these checks or action taken. The Freezer log sheet was confusing. It had a printed log sheet which related to the temperatures for a fridge but the print was crossed through with an added handwritten instruction giving correct protocol for staff to report temperatures if they were warmer than minus 18 degrees centigrade. The log sheet had been completed and showed no incidents of the freezer having been outside of the required temperatures.
- Expressed breast milk that needed storing was identified with a label showing the mothers name and infants name with no other form of identification. The protocol for collecting milk to feed a baby was for two staff to check the label but if a mother collected the milk they did not need to have the label checked. This would present a risk if there were two babies with the same

# Services for children and young people

name. In response to us raising concerns at the time of our inspection the senior sister told us she would be reviewing the labelling and checking process of stored breast milk.

- Each dedicated children's area had resuscitation equipment appropriate for babies, children and young people. We saw that this equipment was checked daily and that this checking was carried out consistently. All bed spaces had equipment available for use in an emergency with a variety of paediatric sizes.
- Some children were looked after in areas of the hospital not designed specifically for children. The day surgery unit was used for adults and children who were undergoing surgical procedures. Toilet facilities on the unit were designated as male and female and used by adults and children. Changing areas with lockers for adult and children's use were separated by curtains. Children and young people waited for their surgery in a separate play room and could be observed by staff through a large window. When the child or young person was waiting to go home they could wait in the general waiting room used by adults. This had a circle of chairs dedicated for children's use and was surrounded by chairs used for adults waiting to go home.
- The Shalbourne unit was a ward accepting privately funded patients and occasionally looked after children over the age of 12 years as day cases. The admission criteria stated that children would be admitted as a day case and be aged 12 years or above. All children who were less than 12 years of age, or smaller than an average 12 year old, would be cared for on the children's ward. Children and young people who needed to stay overnight would transfer to the children's ward. The admission criteria for patients being cared for on the Shalbourne Suite was decided following a risk assessment in August 2012. At this time actions had been identified but there was no record of the actions having been completed. There was no paediatric resuscitation equipment in the unit. If there were to be an emergency situation for a child on Shalbourne Suite we were told they followed resuscitation council guidance where adult equipment would be appropriate for use on children more than 12 years of age. Staff told

us the paediatric emergency team would attend an emergency situation for a child. This team included paediatric medical staff and nurses trained in paediatric resuscitation.

- The dental area arranged dedicated lists for paediatric surgery and had equipment suitable for children including appropriate resuscitation equipment. The waiting area had a few toys but no separate waiting area for children.
- Sluice areas were tidy with clinical waste appropriately stored and removed by support staff.

## Medicines

- On the units we visited, we found medicines were securely stored in locked rooms. Controlled medicines were stored in separate locked cupboards and were checked daily by two qualified nurses to ensure stock levels were correct.
- Staff followed trust protocol by checking and recording medicine fridge temperatures daily. This ensured that medicines stored in fridges were kept at the correct temperature to be safely utilised. Intravenous fluids were stored safely away from access by children and visitors.
- Audits recorded medication administration errors. We saw minutes from medicines management meetings where errors had been discussed and action plans formulated to prevent a recurrence. For the month of June 2015 three errors had been noted for the children's unit including SCBU.
- Nursing staff told us paediatric pharmacist visited the children's areas daily and were available to offer advice to staff overnight and at weekends through on-call pharmacy arrangements. It was not clear that specific paediatric pharmaceutical advice was available at all times out of hours.
- The paediatric unit was using paper medicine charts which we found were legible, signed and dated appropriately indicating what medicines had been administered or were no longer prescribed. Pharmacists would sign the charts once they had checked them for compliance to trust policy. We saw two medicine charts with missing information which were signed by the pharmacist as being compliant. We saw oxygen being administered which had not been prescribed or signed

# Services for children and young people

for on the medicine chart. This is not in line with trust policy on medicines control and administration. One medicines chart in the dental area had no allergy or weight of the child noted. This meant there was a risk to the child.

- We observed staff following trust protocol when administering medications to children using the name band and talking to the child and parents to verify identity.
- The Shalbourne unit had a box of medications suitable for a paediatric emergency. Staff told us the medicines were checked by nursing staff and pharmacy but could not recall the frequency. These checks were not recorded. This could result in out of date medicines being potentially used for children.

## Records

- Patient records were stored electronically, and in paper format within a trolley secured by a number coded lock. On one occasion we saw this trolley left open and unsupervised in an area that patients and visitors used freely. The electronic system held information about the child or young person's medical history and was used to communicate with GP surgeries.
- Charts used for monitoring a child or young person's condition and nursing needs, such as fluid charts and observation charts were kept at the end of each bed, cot or outside their side rooms. This meant they were available for staff to view when caring for the child.
- Each area to which a child or young person may be admitted had its own system for recording the patients' needs. The records we looked at documented information specific to the needs of the child and we saw that core screening had been completed for each child; this included risk assessments for the patient's safety, infection control, pressure areas and moving and handling. Care plans were in place and some contained generic paediatric core care plans that were individualised for each child depending on their needs. Of the 18 records we looked at not all were complete. Of eight patients admitted to the paediatric assessment unit six had no blood pressure recorded. Records of patients on the ward showed seven occasions when the name and grade of the professional reviewing the patient was not clearly documented.

- Observation charts (temperature, pulse etc.) were available for children and young people of different ages. These charts were comprehensive and included a Paediatric Early Warning (PEW) score section, a pain management and assessment section and a handover section. The observation charts had been completed consistently and on two occasions deterioration in the patients' condition had required action which was documented. On SCBU we saw black and white Neonatal Early Warning Score (NEWS) charts being used to record children's observations. Staff told us they were not allowed to photocopy anything in colour as it was too costly. NEWS charts rely on colour to easily identify when a child's condition was deteriorating and being in black and white reduced the clarity of when to escalate a child's deterioration.

- Audits of PEWs charts completed by staff in the children's ward and in SCBU, were undertaken quarterly with results and action plans documented. The audit for March 2015 showed high compliance of between 93% and 100% in all areas audited.
- We saw the World Health Organisation surgical safety checklist was in use and completed appropriately for all surgical procedures for children. Audits of compliance with using this checklist were undertaken for all ages of patients attending the theatre department. It was not possible to separate the data that applied to children and young people.

## Safeguarding

- The trust had a team with responsibility for safeguarding children consisting of named professionals. This team included a clinical lead, nurses and representation from the board. Trust policy states "all clinical staff working with children young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concern should complete a minimum of eight hours, face to face training". Records showing compliance with level three safeguarding children training was 53% which was below the trust's target of 80%. At our visit we were told this had risen to 66% and a new trainer was delivering level three safeguarding training. Senior staff were

# Services for children and young people

monitoring compliance and anticipated that 95% of all relevant staff would have attended this by March 2016. Compliance with level one and level two safeguarding children's training was above the trust target of 80%.

- The named nurse for safeguarding received supervision three monthly from the designated safeguarding nurse. She had recently updated her knowledge by attending a three day conference in Edinburgh run by British Association for the Study and Prevention of Child Abuse and Neglect.
- All nursing staff we spoke with could identify the lead for safeguarding children. Some had reported concerns and others were able to describe what they would do if a concern arose about a child's safety. Outreach nurses received safeguarding supervision at least eight weekly.
- The electronic record that staff viewed as part of the patient admissions procedure flagged whether a child had any safeguarding concerns or social care input.
- Only 33% of paediatric medical staff had completed level three safeguarding children training. Consultants who had contact with children felt training was not appropriate for their needs and had made alternative arrangements to update their knowledge and skills. It was not clear this had been approved by the trust. Any safeguarding training and discussions they took part in was documented in a diary and reviewed at appraisal to assess whether they had achieved the required level of training. The clinical lead for safeguarding children attended local safeguarding children's board (LSCB) meetings and fed back to consultants at meetings or by e mail.
- A recent serious incident had been reported after a delay in reporting a safeguarding issue to social care. This was similar to an incident a few months previously where medical staff had waited for results of investigations before reporting a concern. The ward manager told us she felt that medical staff looked into clinical investigations before reporting potential safeguarding issues. An action plan documented the need for further supervision of nursing staff to enable them to challenge decisions made. Medical staff discussed safeguarding issues at their weekly handover meetings although it was not clear that this specific issue had been discussed.

- The day surgery unit had designated male and female toilets for use by adults and children. Patient changing areas used by adults and children, were separated by curtains . This could pose a potential safeguarding risk for children.
- Where children or young people failed to attend an outpatient clinic appointment, either as a new referral or a follow up appointment, contact would be made with the child's GP requesting a re assessment and re-referral by the GP. If there were concerns about the child or a social worker was involved the GP and the social worker would be informed. Staff had access to the managing child missed health appointments policy and guidelines for children and young people September 2015, which contained a flow chart of actions to take. Outpatients staff were clear about the actions they would need to take and where to seek advice.

## Mandatory training

- Staff told us there was a training tracking tool that informed staff and their managers of outstanding training needs. The trust had a target of 80% staff compliance with mandatory training. In July 2015 the children's service overall, was below this target in some areas including advanced basic life support, consent, mental capacity act training, infection prevention and control and paediatric basic life support. Paediatric medical staff were below the compliance target in 18 out 28 modules. Other children's unit staff were below this target in five of these modules. A clinical educator had carried out a training needs analysis for the paediatric nursing staff. A consultant paediatrician had recently introduced training for all grades of staff which involved an emergency scenario and debrief. Staff who had participated in this training told us how effective the training had been. There was always a member of staff on duty on the paediatric ward who was trained in european paediatric life support.
- The trust employed a clinical educator for paediatrics. The clinical educator we spoke with Life support and child protection training would remain the responsibility for the ward manager to monitor. 70.8 per cent of nursing staff were compliant in paediatric life support, and 80% in advanced basic life support.

# Services for children and young people

- Staff on the day surgery unit had attended paediatric basic life support and had a plan in place to ensure all staff would be trained in paediatric intermediate life support by November 2015.

## Assessing and responding to patient risk

- Each child had a paediatric nursing assessment on admission. These included risk assessments in relation to manual handling, nutrition, pain and pressure ulcer risk and were completed in the records we examined during the inspection.
- Staff updated information about risks to patients as a safety cross for staff and visitors to see. This indicated the number of incidents such as falls and pressure ulcers and was updated daily. There had been no incidents for the month of September.
- All the wards and departments where children were cared for used an age specific paediatric observation chart. They included a paediatric early warning (PEW) score that helped staff recognise when a child's condition was deteriorating and when to seek further help and support from medical staff. The staff we spoke with were all familiar with PEW scores and problems had been escalated appropriately in the records at which we looked.
- World Health Organization (WHO) surgical safety checklists were used in theatres and for dental procedures requiring anaesthetic. The staff we spoke with were all aware of the checks that needed to be done to make sure that consent had been obtained for each child for the correct procedure.
- The children's ward had two rooms near the nurses station which was used for children who needed closer observation. These were treated as high dependency beds although the trust was not funded by commissioners to provide this service. If the child's condition deteriorated further they would be transferred to the intensive care unit at the hospital and if necessary, on to a specialist unit outside of the trust. SCBU had a process in place to transfer babies who needed more intensive medical care. In the short term this could involve transfer to the intensive care unit at the hospital or directly to a local children's hospital.
- Staff followed transfer protocols when children were moved to the recovery area after their operation. This

was to ensure patients' needs were assessed and staff accepting the patient had a comprehensive handover. A parent was allowed to be with their child in the recovery area of the day surgery unit. If the child was going to a paediatric ward post operatively a qualified nurse escorted the child back to the ward with the parent(s).

- We observed staff handovers where staff discussed the clinical needs of the patients and followed up with a more individual handover in the bays. Handover in SCBU included checking the charts were completed correctly to ensure staff were fully aware of what care was needed.

## Nursing staffing

- Staffing levels on the paediatric unit was assessed using Royal College of Paediatric and Child Health guidelines. Staffing levels were reviewed six monthly at board meetings. The discussion at the board meeting of August 2015 recorded a difficulty in recruiting registered nurses which was affecting the implementation of staffing models. The divisional director of nursing for women's and children's services had redesigned the nursing vacancy advert resulting in the recruitment of senior nurses for the ward within the previous six months. The RCN document 'Defining Staffing Levels for Children and Young People's Services' states: Patient dependency scoring should be used to provide an evidence base for daily adjustments in staffing levels. Ward managers did not use an acuity tool to assess how many staff were needed per shift.
- Each shift had a senior nurse in charge who acted as a co-ordinator and was qualified in European paediatric life support. On the ward the expected staffing levels for 16 patients per shift would be three registered paediatric nurses and one health care assistant during the day and three registered nurses at night. Rotas showed where bank staff had filled the shortfall of staff and that a registered nurse qualified in paediatric care was always on duty. Winter staffing levels increased on 1 October to four registered nurses and one health care assistant each day shift and four registered nurses at night. The reason for the increase in nursing was to cope with the predicted increase of children being admitted with respiratory problems. The ward increases its capacity in the winter from 16 beds/cots to 20 beds/cots. The two high dependency beds on the ward would be staffed by one of the rostered qualified nurses. If the

# Services for children and young people

ward had reached its capacity, the nurse to patient ratio would not have met the recommended one nurse to four children (if more than two years old). At the time of our visit the ward was not full to its capacity.

- Children's outpatients was staffed by a health care assistant from the ward and two clerks from the general outpatient department. When clinics were being held there was always a senior medical practitioner or qualified nurse in the department.
- If the SCBU were full to capacity with highly dependent babies, British Association of Perinatal Medicine (BAPM) staffing requirements state a need for nine qualified nurses per shift. Rotas for the previous two weeks showed four to five qualified staff working each shift. No acuity tool was used to define how many staff were required to safely care for the numbers of babies on the unit at any one time. At the time of our visit there were two high dependency cots and 13 special care cots occupied by infants. Four registered nurses and one nursery nurse were on duty which was compliant with the standards recommended by BAPM.
- The intensive care unit at the hospital cared for 24 under 18 year olds between October 2014 and September 2015. The length of stay was between three hours and 22 days. Nine of these children were discharged to a specialist paediatric or neonatal unit in another hospital. Nurses were not paediatric trained but all band six nurses had completed additional training entitled 'caring for child in adult setting'. We were told two of these nurses would be on duty if there was a planned child admission.
- The day surgery unit, Shalbourne Suite and the dental surgery team had no qualified paediatric nurses within their teams. If children needed to be cared for by paediatric nurses the child or young person would be moved to the paediatric ward.
- The day surgery unit had a second recovery area for adults and children who were planning to go home the same day. There were five spaces for patients to wait and space for one relative to sit with each patient. One nurse cared for these patients. The nurse also collected patients from the theatre recovery room, informing another staff member on the unit of her actions. During this time, children were left in the care of their parent.

- There was a trust list of bank nurses who were available for the paediatric unit to cover unexpected staff absence. An induction programme was in place for these staff before they worked on the wards. Staff told us the bank nurses who worked on the paediatric unit were familiar with the ward processes.
- Sickness rates were stable throughout the year and for May 2015 were 8.5% on the paediatric ward and 5.4% on SCBU. The sickness rate was above the trust's target of 3.5% sickness rate but similar to other areas within the trust.

## Medical staffing

- In June 2015 the proportion of consultants employed by the trust for acute children's services was higher than other similar services in England by 6%. The proportion of junior doctors was similar to other hospitals in England.
- The weekend and night time on call rota consisted of one middle grade doctor, a junior doctor and a consultant on call from home. This left a junior and a middle grade doctor to cover the needs of four areas; SCBU, paediatric ward, labour ward and the emergency department. Nursing staff expressed a concern about the potential need of emergency medical support for a child on the ward when the two doctors were busy in the other areas. In addition, the rota we saw for the week of 28 September 2015 had two night shifts which were staffed by locum doctors who may not have been familiar with the trust. Consultants were able to reach the hospital within 30 minutes of being called.
- Junior doctors had a four or six month attachment to paediatrics as part of their training. There had been a reported shortage of trainee doctors resulting in the unit having six allocated doctors instead of the eight they need to comply with European Working Time Directives for doctors. There were no nurse practitioners for this department and no plans to train nurses to this level. We were told there had been agreement with the board members to fund two further consultant posts both of whom had been appointed, however, only one of these posts was currently being funded by the trust.
- There was a daily consultant round and records showed no child admitted to the ward, had waited longer than 24 hours to see a consultant.

# Services for children and young people

- We observed the formal handover between all grades of medical staff which included discussions about consent, discharges, safeguarding and planned investigations.
- All locums were expected to complete an induction booklet prior to working at GWH. Some of the subjects it covered included infection prevention and control, hand washing expectations when to use hand sanitising gel and the procedure for reporting incidents.

## Major incident awareness and training

- Staff we spoke with were aware of their roles in the event of a major incident and were able to describe actions they were required to take.
- Systems were in place to increase the bed capacity for children being admitted over the winter months when respiratory problems were expected to increase.

### Are services for children and young people effective?

Good



We found effectiveness of services for children and young people in Great Western Hospital to be good.

The services were involved in national audit and followed guidelines to ensure children received care that was recommended as being effective. Staff had responded to the results from audits undertaken by changing practice in order to improve the care they delivered.

Staff appraisals supported staff development and were up to date for most staff. Staff competence was monitored by senior managers who also provided nurses with tools to support their new revalidation procedures. Available training enabled staff to add to their skills and a newly appointed practice educator was working on a training plan that would provide further training and updates on relevant skills for staff

Parents were involved in the care of their children and any decisions that needed to be made.

Staff understood issues of consent and ensured children and parents understood the consequences of decisions made. We saw excellent examples of children being empowered to make their own decision on how they wanted their care to be delivered.

Staff collaborated with other parties (for example parents, schools and outreach nurses) to accommodate patients' needs and ensure they could access their normal activities as much as possible.

## Evidence-based care and treatment

- Policies, procedures and guidelines were available to all staff via the trust's intranet. There were some local guidelines on the intranet as well as a hyperlink to more up to date guidelines from a local childrens hospital. Staff were advised to follow these guidelines but this could be confusing for staff and result in out of date guidelines being followed. Documents and pathways of care had been developed in line with guidance from a variety of sources, for example: NICE Guidelines in Neonatal Jaundice (CG98) (May 2010) and guidelines for management of acute asthma were compliant with British Thoracic Society recommendations. Transition services following NICE guidelines were being developed for children. This was to prepare children to feel supported when they needed to move into adult services. For example children living with diabetes started this transition at around 12 years of age by having access to a diabetic nurse for young people.
- SCBU had achieved stage three accreditation of the Unicef Baby Friendly Initiative which assesses whether parents have been supported to have close and loving relationships with their baby; that they are valued partners in care, and that babies are enabled to breastfeed/receive breastmilk when possible.
- Skin to skin care (an established method of promoting bonding, lowering stress levels and optimising brain development) was encouraged by staff in SCBU with leaflets and physical support where needed. We saw mothers engaging in skin to skin care with their infant.
- An audit of compliance with guidelines from the Association of Paediatric Anaesthetists (2011) identified actions for improvement in dental referrals, which were shared with staff and plans were to re-audit their service.

# Services for children and young people

## Pain relief

- The ward used an age specific paediatric observation chart. For children less than 11 years old, charts displaying happy and sad faces were used to help assessment of pain. Paediatric pain management recommendations and a visual analogue scale (scale of one to 10) were used for older children and young people. The link nurse for pain management had her contact details on the chart. The children we saw were able to respond to questions about pain and were kept pain free.

## Nutrition and hydration

- Meals were served from a heated, trolley once they had been checked as being at the correct temperature and children could then choose what they would like to eat. Snack trolleys were available on the wards. A variety of cutlery and feeding cups were available to suit the child's individual needs. We saw post-operative young children offered a variety of snacks to encourage them to eat.
- The paediatric departments had access to paediatric dieticians who were available for specialist advice and support with diets and food. Staff were aware of how and when to access the dietetic service. Staff were also aware of how to order specialist menu choices such as vegetarian or gluten-free meals.
- Records reviewed showed that any fluid or dietary intake was monitored and recorded where necessary.
- Dieticians visited SCBU twice a week to offer advice, and speech therapists were available to assess and support babies who had problems swallowing.
- Nurses on SCBU, four of whom were breastfeeding champions, were able to support new mothers with breast feeding and facilities were available if mothers needed to express breast milk.

## Patient outcomes

- The number of multiple emergency admissions (February 2014 to January 2015) for children aged between one and 17 years living with
  - asthma was lower than the England average.
  - epilepsy was higher than the England average.

- Diabetes was very low and to protect patient confidentiality specific numbers have not been provided.
- Data for January to December 2014 showed emergency readmissions were lower than the England average following surgery:
  - There were less than six readmissions after elective surgery for any specialty, among patients less than 17 years of age.
  - following non-elective surgery in the under one age group was 2.8% against the England average of 3.3%.
  - 2.1% following non-elective surgery in the one to 17 age group compared to the England average of 2.7%.
- Paediatric diabetes audit performance for 2013/14 published in October 2014 indicated that the trust performed at a similar level to the average for England and Wales
- The dental department were involved in an audit using the Association of Paediatric Anaesthetic guidelines. The incidence of children having repeat general anaesthetic procedures for dental extractions between October and December 2014 was 6.4% which was within the national range of 3.1% - 11.9%.
- Outcome's for babies receiving care and treatment on SCBU varied in comparison with the national average across a range of measures in the National Neonatal Audit Report for April 2014 - March 2015. There were some issues with poor data quality in certain aspects of the audit programme.
- The unit score was average or above average for:
  - treatment.
  - The unit achieved below average results for
  - Retinopathy or prematurity screening.
  - Documenting blood culture results for all infants started on antibiotics
  - Documenting the proportion of parents seen within 24 hours of the admission of their baby.
- There was incomplete data being recorded on the data collection system for retinopathy of prematurity screening. Two previous audits had shown all infants were receiving ROP screening appropriately but this was not always being entered on the data collection system. We were told the process had since been improved.

## Competent staff

# Services for children and young people

- Student nurses told us that they were mentored and supervised by experienced nurses. They said that they had received an orientation to the ward before they started their placement and had all received good support from the paediatric staff while on the wards and departments. All of the student nurses we spoke with told us they were enjoying their placement.
- Nursing and support staff at all levels told us about the supervision arrangements in their own ward/unit areas. Staff on all of the wards and departments told us they “felt they worked really well as a team”. One nurse told us she had been offered more development opportunities during her time on the paediatric ward than in her previous role in another part of the hospital.
- There was a newly appointed paediatric clinical educator who had taken responsibility for supporting newly qualified staff. She had identified some key areas and outlined methods of delivering training for staff to update their skills and knowledge.
- Band six nurses on the ward organised and held two ‘away days’ for all paediatric nurses to attend. This included updating relevant clinical subjects. For example; care of children with respiratory problems as there would be an expected increase in the winter months.
- Specialist outreach nurses had extra qualifications in their specialty and provided updates and advice for ward staff. The specialist nurses in some fields were supported by tertiary centres. For example, the nurse for cystic fibrosis received specialist support from Southampton and provided outreach support for children in Swindon and Wiltshire.
- Medical staff we spoke with all confirmed that they had received an appropriate induction to the trust and to the paediatric departments. Ongoing training was offered at regular meetings with mixed grade doctors for paediatrics. We heard the discussions which were related to patients at handover meetings and incorporated other subjects for update including children’s safeguarding.
- A small number of children, less than two years of age, needed to have an anaesthetic before undergoing an MRI (magnetic resonance imaging). Not all anaesthetists felt they cared for high enough numbers for this procedure in order to maintain their anaesthetic skills for this age group of children. Senior medical staff told us of discussions promoting ideas to support anaesthetic practise. One idea was for colleagues from another trust to work alongside anaesthetists at Great Western Hospital but nothing had been agreed at the time of our visit.
- Surgery for children was performed as part of a general surgical list of adults and children. The anaesthetist for the lists might have been paediatric trained but this was not a certainty. The trust had a policy in place to ensure that anaesthetists were appropriately supported by colleagues who had additional paediatric anaesthetic skills
- A paediatric consultant had introduced a programme of simulated emergency scenarios which included a debrief session and was open to all clinical disciplines.
- The revalidation process for consultants was linked with their appraisal process. The responsible officer ensured revalidation of medical staff was up to date and rates were discussed at board meetings. Senior medical staff told us all of the medical staff had job plans.
- Nurses had received information to help in their own preparation for the new requirements of revalidation. This was sent to all qualified nurses in the trust and incorporated a template for recording their evidence.
- All of the staff we spoke with told us their appraisals were either up to date or they had dates booked. Appraisals had recently been changed to being spread throughout the year instead of between the short period of April and July of each year. This was to spread the workload and may be a reason for appraisal rates appearing low as those due between this time may have been booked for a later date. Appraisal rates for clinical staff were between 76.5% and 100% completion. Rates were monitored monthly and reports were sent to managers who would arrange any appraisals due. One member of staff told us how, at her recent appraisal meeting, further training had been identified for her to increase her skills.
- A high number of nurses had additional specialist skills in SCBU. Twenty four out of 26 nurses in SCBU were qualified in their specialty.

## Multidisciplinary working

# Services for children and young people

- We saw examples of multidisciplinary team working across the paediatric wards and departments. We were told about and observed good working relationships with other health professionals for example infection control staff, physiotherapist, dieticians and speech and language therapists. We were also told of good relationships with other specialist nurses, for example diabetes, cystic fibrosis and oncology. We saw multi-disciplinary ward round on SCBU where doctors and nurses discussed care with parents.
- Babies and children were referred to other professionals when needed. Physiotherapists saw children the same day of referral and at weekends if needed. Dieticians were available for advice Monday to Friday. The child and adolescent mental health service (CAMHS) was managed by an alternative provider and called the ward each day to find out if they needed to visit any children for assessment. Children's ward staff told us a member of the CAMHS team would visit the ward by lunchtime of that day. SCBU staff directed parents to BLISS, a registered charity that supports premature infants and their families.
- We saw a surgeon visit the paediatric ward to see children he had operated on that day and offer advice to the parents, children and nurses.
- Clinical nurse specialists worked with other agencies to support the children and families. The oncology nurse worked closely with hospice services and was able to offer support in a variety of ways to suit the child using support from the hospice. There was a transition clinic held for 16 to 17 year olds living with diabetes. This included a nurse who was skilled in supporting young adults, psychologist, paediatric consultant and dietician.
- The ward had a room used by teaching staff to support children with their education while they were patients on the ward. Teaching staff communicated with the ward staff about the needs of the child and arranged the education around the child's health needs.
- We observed how effective communication between the ward and radiology had resulted in a child having their radiological procedure over an hour earlier than planned allowing the family to go home sooner than expected.

- A play specialist was available in the ward area to offer distractions for children of all ages. Children showed us some of the activities they had been given and told us how they had enjoyed talking to her.

## Seven-day services

- There were seven-day services within the paediatric wards and units, with the exception of day surgery and outpatient clinics. Services such as diagnostic and pathology were available for children and young people seven days a week and out of hours. Play specialists were available five days a week.
- Consultants reviewed their patients daily on the ward rounds seven days a week and were available out of hours via on-call arrangements.
- Physiotherapy, paediatric pharmacy and imaging services were available out of hours.
- The outreach oncology nurse organised support at weekends and out of hours for children if needed.

## Access to information

- The ward clerk organised records to be available for the planned admission of children which they told us were usually available within a few hours. Records stored off site could take a couple of days to arrive.
- The children's outpatient department had a system to ensure records were available for the child's attendance. Staff we spoke with told us they had not had any problems with notes not being available but they had no evidence of any audits to demonstrate the availability of notes.
- GPs were able to refer children in to the paediatric assessment unit if they needed further clinical advice. This service changed at the time of our visit. It had previously required the GP to call the junior doctor on duty at the time who would document the details and see the child when they arrived at the unit. This changed to the GP being able to call for advice and speak to a middle grade doctor or consultant for advice on clinical management of the child. We were told the aim of the change was to reduce the incidence of inappropriate referrals by giving specialist advice for the ongoing care of the child or young person.

# Services for children and young people

- Discharge letters were sent to GPs regarding the clinical needs of the child and their stay in hospital. These letters were sent electronically to GPs or by hard copy if the GP was not on the secure electronic information sharing system.

## Consent

- Staff demonstrated the use of Gillick competencies principles (used to help assess whether a child has the maturity to make their own decisions and to understand the implications) when making decisions about people's ability to consent to procedures, especially with adolescent patients. We witnessed nurses involving children and young people in making decisions about their care and treatment and using terminology the child could understand.
- Consent was obtained from parents or carers for each child or young person who was not able to consent for themselves. Staff were aware of the appropriate procedures in obtaining consent. We saw staff talking to and explaining procedures to children in a way they could understand.
- We saw examples of how staff on each ward/unit involved children and young people in their care and treatment and would seek the child's consent prior to doing anything, for example, taking a pulse or blood pressure or undergoing an intervention. On one occasion a child refused to undergo a planned surgical intervention. Staff respected the child's decision but helped the child to understand the impact to their health. They took time to find out what would help the child to have the recommended surgery and agreed further actions with the child. Further dates were agreed for the child to visit the recovery area, theatre and ward areas to reassure the child. Parents were in attendance at this time but the child made the decisions with the information provided by the nurses.
- Care plans were used for children undergoing treatment for oncology. We saw plans that had involved decisions made by the child, how they changed and of how they wanted to be supported and cared for at the end of their life.

## Are services for children and young people caring?

Good



We found the services for at Great Western Hospital to be good at caring children and young people. We witnessed compassionate and appropriate care from all staff in the areas we visited. Parents felt involved and able to leave their child under staff care. Feedback from patients and parents was mostly positive.

Children felt cared for and put at ease on the children's ward by staff who were skilled at building relationships quickly and communicating effectively with children and young people of all ages. Staff listened to children and actively sought their consent helping them to access treatments even when they felt apprehensive.

Emotional support was available for children and their parents and space was available for private discussions.

Children and families were treated with compassion and respect and given time to ask their questions without being rushed.

Outreach nurses established creative ways of helping children with long-term conditions, to be as normal as possible without feeling unsafe.

## Compassionate care

- Friends and family test results showed positive responses but the response rate was low. Staff told us the friends and family questionnaire was given to children/parents on their admission, however children and parents told us they had not seen the questionnaire. Parents and patients we spoke with were aware of and could access a suggestion box on the ward to provide comments if they wanted to.
- CQC survey results for 2014 showed the trust scored about the same as other children's services in England for most of the questions asked. It scored better for 8-15 year olds feeling that staff talked to them about their care in a way they understood.
- During our visit we saw compassionate and caring interactions between staff, children and young people and their parents. Staff were skilled in communicating with children and young people; we observed this on every department we visited. Children and young people and their relatives told us they were happy with

# Services for children and young people

their care in all areas of the paediatric departments. They said that staff were very caring. One relative said they “if these guys weren’t as good as they are we’d have gone under”.

- We also saw ‘thank you’ cards on the ward and units from parents and children expressing their thanks for the care provided.
- Staff interactions with children and their families were friendly and welcoming. Staff were child focused and we observed many examples of where staff had established a trusting relationship with the child and their family.
- When a surgeon visited a child post operatively, we observed a nurse gently reminding a parent of questions the parent had wanted to ask.
- Teenagers we spoke with said how they thought the nurses were “amazing” going on to say how they had made them feel at ease.

## Understanding and involvement of patients and those close to them

- We saw how staff explained things to parents and children and young people. For example, we saw a nurse explaining a procedure to a child. We saw how this reassured both the child and their parent. Two of the parents we spoke with felt the doctors were not very informative.
- We observed ward rounds in SCBU where the team involved parents in making decisions about their child’s care.
- We observed clinical interventions on children which involved good preparation of the parents and children with age appropriate communication and praise.
- Parents we saw were encouraged to be involved in the care of their child as much as they wanted to. We heard staff engaging with children and young people of all ages appropriately.
- Staff were able to build relationships very quickly with parents, children and young people. We saw evidence of this during observation of a pre surgery assessment where staff supported the child and parent and ensured they understood the forthcoming procedure.

- Staff in SCBU explained procedures to parents and directed them to recognised charitable organisations that would support them with further information and peer support for any ongoing needs.

## Emotional support

- Clinical nurse specialists provided support for parents and children for a variety of conditions. Though an outreach service they had a room on the ward as a base and communicated well with the staff. We were told how a family had been supported to receive specialist care in the hospital and still attend their usual school. This had helped them to feel safe and access their normal activities.
- The hospital had a chaplaincy service available if it was needed by parents or children.
- Children and young people who needed surgery were able to be accompanied by their parents to the anaesthetic room and stay with them until they were asleep. This ensured that parents were able to continue to provide emotional support for their children. Parents were able to see their child in the recovery area as soon as they were awake to provide reassurance and support.
- The transition team had a psychologist who could offer support for diabetic children and planning their move to adult services.
- The diabetic team held drop in meetings for children and young people to meet socially which provided support from their peers.

## Are services for children and young people responsive?

Good



We found the services at Great Western Hospital to be responsive to the needs of children and young people and their families.

Children’s ward staff allocated beds in such a way that would keep similar ages together and separate male and female, protecting a child’s dignity and privacy. Parents’ needs were planned for with facilities to stay with their child and areas where they could access refreshments and some privacy from the ward or SCBU.

# Services for children and young people

The trust had processes in place for when a child needed to be transferred to a specialist unit.

Some children were offered a pre operative assessment clinic and a visit to the ward and theatre area before their planned admission in order to reduce anxiety, however this was not offered to all children.

We saw children were given priority over adults in most areas we visited although we saw one occasion of an altered operating list which prioritised adult needs over a child's needs. In some cases this prioritisation brought treatment forward, allowing families to return home sooner than anticipated.

Facilities were available to occupy children and young people of all ages. All areas that we visited had some child-friendly activities or distractions.

The nursing outreach team had a process in place to support longer term care for children who would receive care from adult services when they reached 18 years of age.

Some areas in which children and adults were cared for together were not always the most appropriate for children. Children could receive post-operative care next to adults or be able to view adults in gaping gowns as adult and child waited for their surgery.

## Service planning and delivery to meet the needs of local people

- There were no formal focus groups available to help children, young people and their families in contributing to planning children's services. The oncology nurse used a charitable organisation to gain the views of families using the service. The children's outreach service was designed to work flexibly depending on the changing needs of the child. They were able to see children at home, at school or at hospital based clinics depending on the child's needs at the time.
- Most outpatient appointments for children and young people were held in dedicated paediatric facilities. A parent told us their child had an appointment within a month of the GP referring them. Once they arrived at the outpatient department they were seen quickly.
- The children's ward was arranged in way that could be flexible for the changing needs of patients. Staff told us they kept boys and girls in separate bays and similar ages of children and young people together. At the time

of our visit we saw a bay of three teenage girls together and another bay of children less than 10 years old. Separate areas suitable for teenagers or young children were available if patients wanted a break from their ward area.

- All children and young people attending for surgical procedures were cared for initially, in an area used for adults as well as children with children nursed alongside adults. There were areas placed within adult areas which were dedicated for use by children and young people. For example, a play room for when children or young people were waiting for their surgery and when waiting to go home.
- Parents rooms were provided on the children's ward and on SCBU for them to have some time away from the ward and prepare drinks. The CQC survey results for 2014 rated the facilities provided for parents and carers staying overnight worse than other trusts in England.
- The children's ward and SCBU had escalation plans for when there was lack of capacity or higher demand for their services. All staff we spoke with were aware of these plans.

## Access and flow

- Children and young people were cared for in bays of four patients or individual side rooms. The Bays were allocated to same sex, similar aged patients. At the time of our visit we saw this to be the case.
- Babies in SCBU were cared for depending upon their clinical need. There were separate areas for babies who needed close observation and those who could be observed by nurses and receive more contact with their mothers.
- Some children attended a pre-assessment clinic before their surgery. The decision for this was made by the consultants, two of which used the pre operative assessment service for children routinely.
- Patients attended the day surgery unit to have their surgery and recover enough to be discharged home or to transfer to the children's ward for further care if it was needed.

# Services for children and young people

- Children and young people on the day surgery unit were able to have one parent with them until they were ready to go home. Those who were further cared for on the children's ward were able to have both parents with them.
- Surgical lists were arranged with children undergoing their surgery early in the day and before adults where it was possible. We witnessed an occasion when a surgeon changed the order of patients on the list resulting in an adult undergoing their procedure before the child in order that the adult could go home sooner. The child had also been planned as a day case, to be returning home the same day.
- The paediatric transfer policy was accessible for staff when children needed to be transferred to another area of the hospital or to another hospital. This could be due to a deteriorating condition or when there was a greater demand for paediatric beds. Staff were able to describe actions they needed to take in order to transfer patients and included assessing the clinical need. Children and young people were not usually given the choice of being cared for on an adult ward until their 18th birthday. We were given an example that if the young person was between 16 and 18 years of age and had undergone orthopaedic surgery it would be appropriate to nurse them on an orthopaedic ward in order to make a bed available for a younger child needing admission to the children's ward.
- Discharge plans were discussed at ward rounds and medications needed at home would be ordered. Staff told us if there was a risk that the discharge of a child or young person would be delayed due to waiting for medications, they would provide a prescription for the parents to collect medications from another pharmacist.
- The system for informing community services of the child's needs after discharge was generated electronically for patients within the area. Information would be sent by post to GPs or other professionals outside of the area. Discharge reports were given to parents who could then raise any concerns with the hospital doctor or their GP.
- The children and young people thought the food was generally good. One parent told us the food "is bland". A teenager told us it took her a long time to get to the trolley so her choices were reduced by the time she got there.
- A range of information on particular procedures and conditions was available for parents. We saw easy to understand information displayed as posters on the ward.

## Meeting people's individual needs

- There were support mechanisms for parents of babies who were being cared for in SCBU. Ongoing support for parents and their babies was soon to be available from the breast feeding outreach team. We saw lots of 'thank you' cards and letters, on wards and departments visited, showing families' appreciation for the support offered.
- Some children who had complex needs or needed complex surgery, would attend a pre-admission clinic a few weeks prior to surgery. The pre-assessment clinic would offer services to reduce anxiety in the child. These children would be offered a visit to the day surgery unit and theatre area to help the child feel more familiar with the process. The pre-admission clinic staff prioritised the needs of children and saw them as soon as they could following their arrival at the department. Staff told us of a time they arranged an alternative appointment for a child as they could see the parent and children were having difficulties coping in the environment. Not all children attending for surgery were offered this pre-assessment clinic.
- The CQC children's services survey results for 2014 showed the trust was similar to other trusts in England for staff who were treating the child being aware of the child's medical history.
- The radiography department had an area with toys where children with learning difficulties could wait and would prioritise the child's needs by using a larger than normal room and performing the planned procedure as soon as they were able.
- The needs of children undergoing surgery were not always responded to due to the environment within which they were cared for. All children attending for surgery were looked after pre operatively, in the day

# Services for children and young people

surgery unit which is an area used for adults and children. The layout of this area meant that children were at risk of witnessing adults, who were attending for their own surgery, in various states of undress, which could be upsetting for children and young people. There was a dedicated recovery area for children immediately following their surgery. The second recovery area was used for both adults and children, separated by curtains and with space for one parent to join their children as soon after their surgery as possible. Children recovering from their own surgery were at risk of being upset by witnessing adult behaviours as they recovered from surgery.

- The children's outreach team were able to individualise care for children and help them to access their normal activities as much as possible.
- The children's ward and SCBU catered to the needs of children. There were reclining chairs for a parent to sleep by their child on the children's ward, private space on SCBU for parents to sleep, play areas for all ages and school facilities. There was access to age appropriate TVs, games machines, DVDs and toys.
- There was outside play space available for children which was secure and equipped with appropriate outside toys. There was also a separate room on the ward where teenagers could go to be away from the general ward. This room was also used when young people wanted more private conversation particularly if they were seeing a CAMHS professional.
- The play specialist was able to spend time with children in the play room on the ward, or take some of the equipment to the cot/bedside.
- There was a school service provided education to relevant children on the paediatric inpatient wards. Where the child was able to, they could attend the school room to make sure they did not fall too far behind in their learning. The service liaised with the child's usual school and could support young people in taking exams if necessary.
- We were told there was access to translation and interpretation services with Polish being a recent addition. This was highlighted on leaflets available to patients and relatives.

- SCBU provided accommodation for both parents to sleep. There were three separate rooms providing privacy for parents. There was a parent's room where they could make something to eat or drink. The children's ward had reclining chairs beside each child's bed which parents told us were comfortable.
- We saw a wide range of leaflets and booklets that explained to children and their families about the services offered across the paediatric services and about resources in the wider community.
- CAMHS services were delivered by an alternative provider who liaised with the ward to assess the need for their services. We were told of an occasion when a teenager had to be moved to an adult ward as they were a risk to patients on the children's ward.
- A children's passport for those with ongoing or complex health needs was encouraged. This was a tool for communicating the child's needs including how they communicate, mobilise and what diet requirements they have. The family brought the passport with them on admission to inform the staff of the child's individual needs.

## Learning from complaints and concerns

- Staff we spoke with were all aware of the complaints process. Staff told us that they would always try to resolve any issues immediately. If issues could not be resolved, the family was directed to the complaints process.
- We saw action plans with feedback to staff regarding complaints made. Minutes of acute children's service risk management meetings reviewed and discussed complaints and progress or action needed. Complaints about children's outpatients were mostly about delays. Staff were aware of any complaints that had been made about their own ward or department and any learning that had resulted from them.
- Information was displayed for patients and relatives explaining how parents, children and young people could raise their concerns or complaints.
- A suggestion box was available on the ward that parents and children could use to make comment or complain. We were not told of any actions resulting from the suggestion box.

# Services for children and young people

## Are services for children and young people well-led?

Requires improvement



Overall we found the leadership of the service for children and young people to require improvement.

The overall strategy for the children's services was not always clear to staff. The decisions made at board level did not always filter through to the staff and very few staff had heard of the 'in your shoes' initiative that helped senior staff to find out what it was like 'on the ground' by working in different areas for a period of time.

Some staff did not know how they would feed any concerns further than their department manager. Some senior staff members said that they felt listened to but that action did not always follow after they raised concerns.

Children's services had no champion representing them at board level.

Local management were supportive to staff who felt that they could approach their managers with any concerns. They felt proud to work for the department and were open to learning from incidents.

The trust's values were widely known and good practice had been recognised at award ceremonies.

### Vision and strategy for this service

- We saw the trust values known as "STAR", service, teamwork, ambition, respect, displayed in all areas we visited. All grades of staff knew about the values and some were able to talk about them in detail.
- Staff told us they did not always feel part of the hospital. Some initiatives had involved the hospital as a whole but not the children's unit. An example we were told about was when wards in the rest of the hospital changed to using a paper assessment of patients' needs instead of the electronic record system. The children's unit was not involved in this development and were unable to access electronic medical histories when access was removed from the whole hospital. The system was reinstated once the trust was informed of the problem.

- Staff on the children's unit had not received any communications about progress and actions of wider initiatives. Staff felt as a unit they worked well as a team and were supported by their managers.
- There was some conflict of vision between the board and senior managers. As an example we were supplied with information from the trust of a strategy to introduce nurse consultants for paediatrics but a senior member of the management team had been told this was not going to happen.

### Governance, risk management and quality measurement

- Issues on the risk register were discussed at the appropriate meetings. We saw the minutes for the acute children's service risk management meeting held in June 2015 which included serious incidents, safeguarding updates, items on the risk register for paediatrics and their progress.
- Staff were clear about their responsibilities in meeting the needs of children and young people. A system of audit demonstrated their performance and was reported to the board regularly to assess how well they were meeting local and national targets. This included statistics for a variety of indicators, referral to treatment waiting times, paediatric activity, NICE guidance and the financial position.
- There was not a strong representation of children's and young people's needs at board level. There was no champion or director for children and young people's services. Representation for children's services at board level was from the associate medical director for women's and children's services. Some staff told us they thought children's services were adequately represented at board level and other staff told us children's services did not get the strength of representation at the board. Some senior staff told us it was difficult to get agreement for any initiatives and they had given up trying.
- The service leads used a number of tools to gather data which was needed to meet the trust's governance arrangements. Incidents, accidents and near misses were recorded and investigated using the trust incident reporting system. Staff were aware of the incident reporting system and were using it effectively.

# Services for children and young people

## Leadership of service

- The staff we spoke with were all aware of who their immediate managers were. Staff described the ward manager and divisional director of nursing as being supportive, approachable and visible. Staff felt well supported by the ward managers and that the divisional director of nursing was busy but they could call her if they needed to.
- We were told by executive directors that they made themselves visible by visiting ward areas regularly although some of the junior staff told us they would not recognise them. There may have been other reasons for staff not recognising senior executives such as not having been on duty at the time of the visit.
- The outreach nursing team felt their designated team leader was effective in providing a line of communication between their team and managers.
- Staff in the outpatient's department were not clear about who managed the department. A health care assistant from the children's ward was present in the department to support children and families when they visited the department. She would take any concerns she had to the children's ward manager. Clerks, who were managed by the adult outpatient department would take any issues to the outpatient department manager. It was not clear who had the oversight of the department.

## Culture within the service

- Throughout the areas we visited there was an atmosphere of friendly interaction between all grades of staff.
- Staff felt respected by their managers and were proud to work in the paediatric department. We heard the comment "I love my job" more than once from staff. All levels of staff felt they could take their concerns to the ward manager and they would be listened to and supported.
- The ward manager was used protocols to manage performance of all ward staff. As an example, she reminded a member of the medical staff to use correct protocol for taking blood samples and informed the doctor's line manager so they could act upon improving skills and knowledge.

## Public engagement

- The children's unit had a suggestion box in clear view of parents and children. Friends and family feedback forms were suitable for adults and available to take freely. Some staff thought the forms were given to parents on admission but were not aware of any protocol regarding patient/parent feedback systems. Parents we spoke with denied having received friends and family forms at the time of their child's admission but were aware of the suggestion box.
- Staff we spoke with did not know of any parent focus groups to capture the views of parents in the design of the service.
- The specialist oncology nurse linked with a charity called CALM (child cancer and leukaemia movement). They met with the medical team six monthly and communicated the views of parents and children who have used the oncology service.
- The divisional director of nursing told us of their plans to involve charitable organisations to make the outside play area more appealing to children. This initiative was at the early stages and there were no plans to involve children and their families at the time of our visit.

## Staff engagement

- Most staff we spoke with would escalate a concern through their line manager. They were not all aware of any other meetings that were held such as open meetings for staff to attend.
- The leadership team told us of a project called 'in your shoes' when senior managers or executive directors would work with any other staff group in the hospital for a period of time. Most staff we spoke with had not heard of this initiative.
- Another senior member of staff had seen colleagues having improvement plans repeatedly rejected by directors and had declined to put forward their own plan as a result.

## Innovation, improvement and sustainability







- We saw areas of practice that were being reviewed and changed in order to improve the services. At the time of our visit the paediatric assessment unit (PAU) changed the way it was reviewing admissions. They had developed a helpline for GPs to discuss options of

# Services for children and young people

treatment. The helpline was to be answered by a middle grade doctor or consultant instead of a junior doctor. The aim of this was to encourage appropriate use of the resource and guide children to the most effective service for their condition.

- The trust had a process where staff could be recognised for work and achievements. Two of the paediatric services received awards for their outstanding practice.
  - The diabetic multi-disciplinary team received the trust's STAR team of the month award in July 2014.
- The paediatric oncology nurse was nominated by patients for the people's choice award which she received at the trust's excellence awards ceremony.
- Some of the senior managers for the paediatric service felt they were not given all the details regarding their budget so found it difficult to encourage innovation. Financial constraints were evident to staff who felt that any change would only be approved if it involved no financial cost.

# End of life care

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

## Information about the service

Palliative and end of life care encompassed all care given to patients who were approaching the end of their life and following death. Care of the end of life patient could be delivered on any ward or within any service of the trust and included aspects of basic nursing care, specialist palliative care, bereavement support and mortuary services. The definition of end of life includes patients who are approaching the end of life when they are likely to die within the next twelve months; patients whose death is imminent and those with advanced, progressive and incurable condition, general frailty and co-existing conditions that mean they are expected to die within the next twelve months, existing conditions if they are at risk of dying from a sudden acute crisis in their condition and life threatening acute conditions caused by sudden catastrophic events.

Great Western Hospital had a service level agreement with Prospect Hospice in the provision of its specialist palliative care team; the service level agreement also set out a contract for the exclusive use of two beds at the local provider to facilitate a smooth and timely transfer of patients.

The in-reach team provided an advisory and supportive service for patients who had an advanced and progressive palliative illness and were usually within the last six to twelve months of their life. The care of a patient remained under the core clinical team with the palliative care team offering specialist advice. The number of referrals to the team has increased every year from 2012/13. The average number of referrals for 2015/16 per month was 110. This

team comprised of 105 hours per week of specialist palliative care nurses, 7.5 hours of manager support and nine consultant sessions per week. The trust employed an end of life nurse. The team had an active role in the formal and informal dissemination of information and new guidance. During our visit we went to nine wards; spoke with 10 patients and five relatives. Whilst on the wards and in the hospital we also spoke with 10 nurses and nine other staff members.

End of life care was delivered in the Great Western Hospital and within Wiltshire community by the Integrated Community Health Division in community wards and people's own homes. This report focuses on the end of life care delivered at the Great Western Hospital there is a separate report for end of life care in the community.

# End of life care

## Summary of findings

We judged the overall service provision of end of life care as good. We found the service to be safe, effective, caring, responsive and well-led.

End of life care was seen as a priority for the trust. There was a clear overarching strategy for the service and plans to improve the delivery of care had already begun to take place with good results. Education programmes had been developed and delivered, new documentation had been successfully introduced to the trust improving the pathway for patients although there was also some, yet to be fully embedded.

Staff, patients and relatives spoke in high regard for the specialist palliative care team; they were seen as responsive to the needs of both patients and staff. Out of hours there were good resources for staff to access including a 24 hour advice line managed by specialist palliative care nurses at a local hospice.

End of life care was responsive to the needs of patients and relatives. The end of life service was flexible and provided choice and accommodated individual needs for the patient and carers.

The specialist palliative care team had been involved in looking at complaints and incidents, as part of a wider team, and were keen to ensure training and teaching sessions were tailored and disseminated to ensure future complaints were minimised and care of patients was enhanced.

The specialist palliative care team were dedicated members of a cohesive team working to deliver effective care and treatment plans for patients, offering advice and acting as a resource for clinical teams.

## Are end of life care services safe?

Good



We judged the safety of end of life care as good.

There were systems in place to make sure that all reported incidents were investigated, staff were clear on the process for reporting and felt able to report appropriately.

Equipment was easily available for patients, however, the syringe pump used to infuse 24 hour drugs was large and cumbersome for patients, and this had to be discontinued during discharge as these pumps were different from the ones used elsewhere within the county.

New documentation, such as the Treatment and Escalation plans to assist staff to care for patients at end of life was being used correctly; however use of the Advanced Care Plan had yet to be embedded into practice. Care plans were difficult to follow and we were unsure how staff could use the nursing documentation to quickly identify patients' needs.

There were processes in place to assess and respond to patients' risk. The specialist palliative care guidance and information was available on the trust intranet and within resource folders available on each ward. There was also availability of a 24 hour advice line managed by the local hospice.

The end of life team were up to date with mandatory training and staff had been trained to recognise and act upon suspicions of abuse with their patients.

### Incidents

- Staff were open, transparent and honest about incidents. Systems were in place to make sure that incidents were reported and investigated appropriately. All staff told us that they would have no hesitation in reporting incidents and were clear on how they would report them.
- There were very few incidents related to end of life care. The lead cancer /palliative nurse received all notifications of the reported incidences in regards to end of life care; the main theme was the development of

# End of life care

pressure ulcers. The lead nurse told us about evidence of learning from an incident involving problems with the syringe driver battery life; this was negated for the future by ordering a long life battery.

- There was one serious incident reported in the core service of end of life in the twelve month reporting period. The incident involved a delivery of a 24 hour infusion via a syringe pump in 12 hours. We saw the incident report which showed an investigation was undertaken and the data from the pump analysed. There was no substantial conclusion from this data and the incident was closed. We did not see any evidence of learning having taken place as a result of this occurrence.
- New fundamental standards and regulation for the provider came into force in November 2014 regarding Duty of Candour. This regulation explains what providers should do to make sure they are open and honest with patients when something goes wrong with their care and treatment. The trust had a comprehensive duty of candour policy in place. Staff were able to demonstrate an understanding of this and senior nurses were able to describe how the duty of candour was part of their working practices. The process they followed was firstly a verbal apology followed up with a written one.

## Equipment

- Staff told us there was a good supply of syringe drivers and pressure relieving equipment and was readily available for use. Staff contacted the equipment library and the equipment was delivered as requested. Out of hours the porters or clinical site manager had access to the store.
- The syringe pumps used at this trust were fairly large pieces of equipment which needed to be attached to a drip stand. Both staff and patients told us they were too big making mobility very difficult. One patient had requested the removal of the syringe due to it affecting her ability to move about. Syringe drivers used in palliative medicine were usually pocket sized and were able to fit into pouches. On discharge home patients needed to have this infusion discontinued as the pumps used in the community services were very different.

Patients would have to have extra doses of pain relief given to ensure they were pain free during their transfer home. This was a risk highlighted on the risk register but there were no plans to replace the pumps at that time.

## Medicines

- Guidance on prescribing of palliative medicines had been produced and was available on the trust intranet, staff were aware of how to access the guidance on the intranet. Pocket cards had also been developed advising on palliative care prescribing, giving direction to the intranet for more in-depth guidance on prescribing, including opioid conversions and renal failure.
- Electronic prescribing had been introduced into the trust. There were difficulties identified with the system in that it was slow to open and medications could be prescribed twice leading to potential errors.
- The specialist palliative care team found the electronic prescribing useful; it enabled them to review patients' medications prior to visiting the patient. Pre-emptive prescribing of anticipatory medications was completed on patients nearing end of life. The electronic prescribing had links to guidance and use of the drugs.

## Records

- In June 2015 the Specialist Palliative Care Team (SPCT) rolled out a document titled 'Personalised Care Plan' in response to the phasing out of the Liverpool Care Pathway. Funding had been sought and awarded from Health Education South West for the delivery of the document. During our visit the document had been in the early stages of implementation and only a few staff had used the document fully. The response we received about that document was all very positive, staff told us they thought it was very good and allowed them to address psychological concerns and enabled them to help focus the care. Treatment Escalation Plans (TEP) and Resuscitation Decision Records were introduced into the trust in August 2015. These plans of care replaced the Do Not Attempt Cardio Pulmonary Resuscitation forms. The TEP document engages the patient at an early stage in their care, to support and help identify the patients' ongoing health needs and clinical treatments and wishes. The TEP was transferable between acute and community care and was adopted both within the primary and secondary

# End of life care

care services in Swindon and Wiltshire. It was only necessary to complete the plan once, although this could be reviewed should circumstances change, and was formally recognised across the healthcare organisations. The use of the TEP was highlighted in computerised patient records and was 'flagged up' on readmission to hospital. A photocopy of the TEP form was taken on discharge home and was kept in the patient's records. We reviewed 11 Treatment Escalation Plans forms and found a high compliance of completion of the forms, dated and signed appropriately.

- Very few staff talked about the Advanced Care Plan (ACP) but we believe this was new to the trust and was being rolled out along with a training programme. The ACP was a discussion held and documented about future care between an individual and their care providers, with family and friends being involved if the patient wished.
- We reviewed 14 patient nursing records, these were in paper format and kept in document holders outside each bay of patients, patients' medical notes were kept in a locked cupboard; we found the care plans were difficult to follow and were not necessarily kept in chronological order. We were unsure how anyone could easily and quickly find out from the care plans what the patients' needs were.

## Safeguarding

- Staff were trained to recognise and act upon abuse or suspicions of abuse of vulnerable people. We saw a comprehensive safeguarding policy in use which contained useful flowcharts for staff to follow. Staff we spoke with were able to confirm the process for referring a patient to the safeguarding team
- The SPCT had all completed safeguarding training as part of their mandatory training programme

## Mandatory training

- The trust provided a programme of mandatory training for staff which included some face to face learning and some e-learning. 100% of the SPCT, including medical staff, were up to date with their mandatory training; this was provided for them at Prospect Hospice.
- End of life mandatory training commenced in July 2015 for all patient facing staff, this was a three yearly requirement.

- The end of life and bereavement team were 78% compliant with all mandatory training. Trust compliance was 80%.

## Assessing and responding to patient risk

- Advice and support from the SPCT regarding deteriorating patients was available on all wards by telephone or visit request. Staff on wards and departments were clear that the SPCT would respond quickly to requests for advice and support. The median wait time for face to face contact with the patient was two days.
- Although we found the nursing documentation confusing and not easy to follow, we did see evidence of risk assessments having taken place. This included risk assessments for pressure ulcers, falls, MUST and bed rails.
- A 24 hour advice line was accessible for all staff to seek palliative care support out of hours; this advice line was given by specialist palliative care nurses and consultants at the local hospice.

## Nursing staffing

- The ward staff were supported in the delivery of end of life care by the SPCT and the end of life nurse. Policies and procedures were in place to guide ward staff ensuring appropriate, effective individualised and patient focused care was delivered to the dying patient and their relatives and carers.
- The SPCT were provided as a contractual agreement from Prospect Hospice. This was via a Service Level Agreement which had been in place for the previous 18 months.
- The team consisted of:
  - 3.8 whole time equivalent (WTE) Band 6 specialist nurses, although one of these posts was a fixed term contract due to end March 2016.
  - 0.2 WTE Band 7 nurse manager
  - 1.0 WTE Band 7 end of life nurse employed by Great Western NHS Trust

## Medical staffing

- The team consisted of two part time consultants in palliative medicine delivering nine sessions a week in total. The SPCT consultants were currently available five days a week. The consultants were accessible out of

# End of life care

hours via the telephone support from the hospice. The consultants divided their working week between the hospital and the hospice. This enabled a link between the two services and provided 'joined up care between the hospital and the community.

- The Specialist Palliative Care Team had seen their workload and referrals increase by 25% over the last three years, however they had just employed a third consultant. They did recognise the need to increase staffing support should they commence a seven day working week. We were told by the palliative care consultant, having a strategy and plans in place had made the management of the service more efficient.
- Meetings were held on Fridays for a handover to the weekend medical team. Unwell patients were highlighted and a summary of the patient's plan was added to the records, this summary was on a bright yellow card, this ensured it was noticeable.

## Major incident awareness and training

- The staff we spoke to were aware of the trust major incident plan and how to access this. In the event of a major incident the mortuary staff were able to identify patients quickly who able to be collected by funeral directors.

## Are end of life care services effective?

Good



We judged the effectiveness of end of life care as good.

End of life care was being delivered through evidence based research and guidance. Education was delivered for clinical staff to update their skills and knowledge in caring for end of life patients. Resources were easily available for staff to access.

Patients were receiving effective pain relief, although due to electronic prescribing this was not always timely.

Weekly multi-disciplinary team meetings were held to discuss end of life patients, capacity and best interests of patients were also discussed; this was attended by a varied group of staff including representatives from other organisations.

The Mental Health Act was not clearly understood by junior nursing staff.

## Evidence-based care and treatment

- End of life care was being delivered in lines with national guidance, such as the NICE guidance S13 End of Life Care for Adults.
- The trust had implemented the five core recommendations for care of patients in the last few days of life in the Department of Health's End of Life Care Strategy 2008. It had also implemented the recommendations of 'One chance to get it right' published by the Leadership Alliance for care of the Dying people 2014.
- We were told the trust had used the Liverpool Care Pathway (LCP) successfully. However, since it was withdrawn the SPCT employed a quality improvement methodology to replace it. The new document was developed using guidance from the Leadership Alliance for the Care of Dying People and was called 'Personalised Care Plan and Information Book (PCP)' and was focussed around the five Priorities of Care. This PCP had been implemented in June/July 2015 and had been under review and had changes made to it.
- In response to recommendations from the national leadership alliance and the national audit for the care of dying people education had become mandatory for all patient facing staff (this included porters, receptionists and ward clerks.).

## Pain relief

- Pain was monitored using a pain assessment tool. A patient told us, when he asked for pain relief the nurses delivered it quickly and they went back to check his level of pain afterwards. We witnessed pain relief medication being administered to a patient; all appropriate checks were made with the patient and the electronic prescription chart. We were told by a patient, one day when they were in a lot of pain the nurses stayed in the room with them after administering pain relief, until they was feeling more comfortable.
- Staff informed us giving pain relief could sometimes take up to 10 minutes due to the electronic prescription being slow.

# End of life care

- We saw correctly prescribed anticipatory medications for patients during the end of life. We did not see any auditing of prescribing of anticipatory medicines having taken place.

## Nutrition and hydration

- Nutrition and hydration was included in the personalised care plan and in all end of life care provided. We observed patients had drinks available within easy reach. Staff told us that snack boxes and drinks were available for patients should they wish for them.
- A patient we spoke, on a medical ward, with explained how he was able to choose off a menu, one day he asked for fish and chips which was not on the menu but his request was catered for. He told us he was able to ask for drinks and snacks when he wished.

## Patient outcomes

- Outcomes were measured to ensure that the needs of patients were being met in the service.
- Feedback on the service was through the National Care of the Dying Audit. The trust had achieved three out of the seven organisational key performance indicators and had action plans were in place to achieve the remaining indicators. They had achieved all of the clinical key performance indicators. Care of the Dying Evaluation (CODE Bereavement survey) was an online bereavement survey validated for relatives to complete when they felt ready, the service was also offered via a telephone through the chaplaincy service. The first results of the first audit were due to have been presented at the patient quality committee in September. The results were used to improve the services.

## Competent staff

- End of life care had become part of the induction and mandatory training programme, these programmes of learning had been devised by the palliative consultant and end of life nurse. There was a great deal of end of life training and education being delivered within the trust and community. The trust employed a part time (30 hours) end of life nurse in February 2015 to assist in the implementation and roll out programme of the personalised care plan for the dying, 'conversation project', which involved a teaching programme in the

use of the Advanced Care Plan (ACP). There was e-learning available for advanced care planning, this document was launched in May 2015 with a ward by ward roll out programme. In 2014-2015 there was a total of 82 training sessions delivered to 736 attendees which equated to 160 hours of education.

- Most wards we visited had end of life champions and an education day was being provided in November for these nurses in order to disseminate information to staff.
- The mortuary manager had developed a training programme in care after death for all ward staff and porters to attend. We were told by a staff member they were due to attend this training the following day.
- A resource folder was available on all wards, a trust intranet palliative care page, symptom management guidelines, and referral guidelines to SPCT were all available.
- A newly qualified nurse told us how end of life care was incorporated into the competencies during their preceptorship time.
- Appraisals had all been completed for the specialist palliative care team apart from one staff member who was relatively new in post. Bereavement team members had also had their appraisals completed.

## Multidisciplinary working

- The hospital held a weekly palliative care multi-disciplinary meeting; these were attended by representatives from the integrated discharge team, matrons, hospice community nurses and representatives from another local community provider. We attended this meeting and witnessed how new patients or patients with particular specialist palliative complex needs were discussed.
- We were told of a patient recently discharged home to their preferred place through a rapid discharge process. Contact was made with another provider to provide overnight care until the care package could be set in place and this happened within a few hours.

## Seven-day services

- The Royal College of Physicians (2014) recommended that hospitals should provide a face-to-face specialist palliative care service between at least 9am to 5pm,

# End of life care

seven days a week, to support the care of dying patients and their families or carers. The specialist palliative care team was available from 9am to 5pm, Monday to Friday. Staff did have access to a 24 hour advice line which was provided by the local hospice. All staff we spoke with were aware of this out of hour's service. The lack of seven day working was identified as a risk to the service and was on their risk register, action plans were being developed to address this issue.

## Access to information

- Staff had access to the end of life care information page on the trust intranet. This held information such as symptom control and prescribing guidance. A palliative care resource folder was also available on each ward; this meant information was readily available for staff to access to aid symptom control for patients.
- Staff were able to access information via the 24 hour advice line at the local hospice.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The more senior staff on the wards were able to demonstrate a good understanding of the mental capacity assessment and knowledge of deprivation of liberty safeguards, but this was not necessarily the case for more junior staff nurses who appeared not to have such a good understanding.
- Patients we spoke with explained how they had been involved in the decision making process of treatment and how they had been asked for their consent whenever it was required but especially when trying new drug regimes.
- SPCT could describe how they had been involved in best interest meetings with the medical teams in discussing with the family preferred place of care. Capacity and best interests were discussed at the multi-disciplinary meetings where appropriate, and mechanisms for ensuring these processes took place. We were told about very detailed documentation and involvement of relatives in a best interest decision concerning a patient in the Intensive Care Unit, where a treatment escalation plan form had been clearly completed and the relatives had been managed very sensitively throughout.

## Are end of life care services caring?

Good



End of life Care was judged as good for caring.

Patients were treated with dignity, respect and compassion while they receive care and treatment. Patients told us how they had been listened to and assisted in being able to make their own choices and decisions about their future care.

Patients received the support they needed to cope emotionally with their care, treatment and condition through the SPCT, the ward and department staff and the chaplaincy service.

## Compassionate care

- We spoke with nine patients and six relatives; they were aware of how busy the nurses were and at times short staffed but overwhelmingly all felt as though their needs had been met in a caring and compassionate way. Patients we spoke with described 'how brilliant' the nurses were; they were 'kind and considerate.'
- Patients and relatives spoke highly of the SPCT. They were grateful for the service and described the staff as caring about their wellbeing.
- Mortuary staff were clear that respect and dignity were an essential part of their job and they would honour the cultural and spiritual wishes of the deceased. They were understanding of peoples cultural preferences and ensured they were met. They ensured they met with families and escorted them to viewings and supported any preferences they might have.
- Ward staff told us that any patients identified as being near the end of their life would be preferably placed in a side room, for privacy and dignity. This would enable family members to stay overnight and have open visiting access throughout the day. A family confirmed they had open access to visiting.

## Understanding and involvement of patients and those close to them

# End of life care

- We spoke with five sets of relatives who told us they had been fully involved and informed of decisions made about their loved one. A daughter told us how the doctor had telephoned her at home as she had been unable to speak with her at the hospital.
- Relatives told us how staff followed their advice about caring for the needs of a patient living with dementia.
- A patient described to us how they had been involved in and helped to make decisions about their treatment and care at all stages. They talked about their preferred place of death and how they made the decision about resuscitation.

## Emotional support

- We witnessed sensitive reviews of patients by the SPCT, recognising uncertainty of time left for patient. Relatives were actively involved in the discussions held and time given for them to ask questions.
- A patient told us how the nurses tried to discuss their emotional needs with them, but they was not keen to talk about it. They was happy there were volunteers who were able to 'chat' to them.
- The chaplaincy provided pastoral care. They offered spiritual care, for patients trying to make sense of their situation and religious care for faith support for the major religions. Ward staff described the input of the chaplaincy service as 'valuable, accessible and supportive'.
- Access to different faiths was available through the chaplaincy service. There was an on-call rota, which was covered by the full time chaplain and six locums who were all ordained ministers. The on call rota enabled access to this service at any time. A team of seven chaplaincy volunteers ensured spiritual support was available.
- The chaplain was involved in developing the end of life strategy and sat on the End of Life Committee and was considered as integral to the end of life service provided.

## Are end of life care services responsive?

Good



We found that the service was responsive to patients' needs.

The trust had involvement from other local services and organisations in the planning of meeting the needs for end of life care across the community and were continually looking at ways to work together to provide a co-ordinated service

We found end of life care and the team responsive to the needs of patients and relatives. The end of life service was flexible and provided choice and accommodated individual needs for the patient and carers.

## Service planning and delivery to meet the needs of local people

- We were informed by the medical director, who was the trust board lead for end of life care, that the commissioners, providers and relevant stakeholders were invited to end of life committee meetings in order to plan the service for future needs of their local people. We saw minutes of these meetings confirming attendance of members. There was at the time ongoing work involving social services to improve timely discharge planning.
- Two beds at Prospect Hospice had been specifically contracted by the trust and available exclusively to them to facilitate the smooth and timely transfer of patients from the hospital to the hospice. We saw appropriate and timely use of this process.
- The service was flexible, provided choice and ensured continuity of care in the wider community. The involvement of other organisations and the local community was seen to be integral to how patient care was planned and ensured the service met people's needs. We heard and saw instances of how the SPCT within the hospital worked with the local hospice and hospice at home team within the community to improve patient support. These included rapid discharges, access to packages of care and equipment at short notice.

# End of life care

- Many relatives told us they had difficulties with the car parking and there were very few disabled parking spaces to meet their needs.

## Meeting people's individual needs

- Patients' individual needs and preferences were central to the planning and delivery of services. Staff were committed to delivering individual needs. We witnessed a dying patient who had been admitted in the early hours. The SPCT visited the patient and their request for a preferred place of death was explored and the patient was transferred that same morning. We spoke with staff in the Emergency Department who told us how patients were cared for in the department. If patients were near death they would remain in the department and moved into a cubicle to respect their privacy and dignity and that of their families and carers. For those patients who had a preferred place to be they would try to instigate this. We saw evidence of this the following morning, when a patient came in who was very unwell. They wished to be transferred to the acute oncology unit and the patient was transferred as requested.
- We visited the mortuary which appeared organised and it was evident that the dignity of the deceased was an ongoing important consideration. Facilities were available for bariatric patients and systems were in place to ensure their ongoing dignity. The staff were keen to facilitate all faiths, beliefs and religions into the preparing of bodies. They were very accommodating to families who wished to assist in preparation of their loved one.
- The mortuary manager had re-written the 'care after death' policy, developed a new bereavement booklet for relatives' reference.
- Bereavement care had been taken over by the mortuary team from the Patient Advice and Liaison Service. This service was available Monday to Friday 8am - 4pm with an answer machine out of hours. The mortuary staff were all qualified mortuary technicians and they were supported by an administrator, who ensured all death certificates were completed properly and collected. The timing of death certificates was not always in line with trust policy which stated collection within 72 hours. This meant the mortuary staff spent time contacting medical staff to complete the certificates.
- The mortuary staff booked viewings and escorted relatives to viewings in the mortuary. They also dealt with the coroner and ensured relatives received patients' belongings and valuables. Out of hours the staff would be on call for urgent viewings, for example, an unexpected death or sudden death. All the mortuary staff had been given extra bereavement training.
- The environment for viewing was clean and facilities were available for relatives to spend time with their loved ones. The staff had plans for the viewing area to be refurbished to make the environment more comfortable.
- We saw staff who had trained as dementia champions across the trust. There was a medical ward designated as dementia friendly. We found there to be guidance on Implantable Cardioverter Defibrillator (ICD) deactivation and flow charts for staff to follow. The SPCT team explained that this was a responsive service to their requests. They generally found the cardiac team had previously discussed with patients this sensitive issue of deactivating the device when the time was appropriate. Once patients had been seen by the SPCT a sticker was placed in the patients' notes, this had telephone numbers for medical staff to ring for out of hour's advice from the local hospice.

## Access and flow

- The SPCT and ward teams worked closely with continuing health care teams, GPs and community nursing teams to support rapid discharge and care in the patients' preferred place. The local hospice were able to assist rapid discharge by providing overnight cover for families for a certain number of nights per week.
- The staff on the wards told us the SPCT were easily contactable and responsive and were very supportive.

## Learning from complaints and concerns

- Patients were aware of how to make a complaint if necessary, there were leaflets available explaining how.
- The specialist palliative care team rarely received complaints pertaining to their service; however they were involved in a general complaint from a patient.

# End of life care

Staff described to us how they met with the family and talked through their concerns. From this experience they were able to develop individual teaching sessions to the staff involved.

- Ward sisters explained to us how they used complaints at ward meetings to discuss the issues and if able to make changes to their practice, this was fed back to the matrons.

## Are end of life care services well-led?

Good



We judged the end of life care as good for being well led.

End of life care services were well led and had been seen as a priority within the trust. The trust had developed a three year end of life strategy, this had been supported by a service review and a commitment to improve the service and care provided to patients and families. Not all of the documentation recently introduced to support the implementation of the strategy was fully embedded yet.

The end of life committee was held monthly and information was fed through to the governance meetings and at trust board level. Risks were identified and actions plans were in being put into place.

### Vision and strategy for this service

- The trust had developed a three year end of life care strategy in 2015. Within the plan they had recognised the weaknesses of the service and developed action plans to improve upon. These included the development of the Advanced Care Plan, the Treatment Escalation Plan and the Personalised Care Plan. The principle objective behind the strategy was 'the patient and family receive the care and support that meets their identified needs and preferences through the delivery of high quality, timely, effective individualised services, ensuring respect and dignity is preserved both during and after the patient's life'. Training was in place to support staff to implement the strategy but the use of all associated documentation was not yet fully embedded.
- The SPCT and end of life team were all aware of the end of life strategy. Staff on the wards were not as aware but recognised the importance of delivering good end of life care.

- When asked some ward staff were able to explain the visions and values of the trust.

### Governance, risk management and quality measurement

- There was a clear structure for governance reporting and risks were identified and understood by the SPCT.
- The end of life committee meeting was a monthly operational meeting monitoring the trust end of life service provision and overseeing the development, implementation and progress of the strategic plans. This committee reported into the trust patient quality committee on a quarterly basis which reported to the trust board. We saw actions from the strategic service review and end of life strategy reviewed from the minutes of these meetings
- There was a risk register specifically for the end of life service, there were three risks identified:
  - End of life care mandatory training (the training had commenced in July 2015)
  - Seven day working for the specialist palliative care team
  - Use of different syringe drivers in the acute trust compared to the community, at the time of the inspection, this was due to be discussed with the divisional directorate.
- The trust had identified a representative from the board of governors to be on the end of life committee. Their role was to provide public involvement and linked the work back through to the governors. The mortuary manager was also a member of the end of life committee and attended the meetings.
- An end of life quality indicator report was submitted quarterly to commissioners demonstrating their progress against the measures of the quality schedule and the Commissioning for Quality and Innovation. This included the key performance indicators, such as number of hours and attendees at end of life education sessions, percentage of patients, known to the SPCT, achieving their preferred place of care.
- Quality assurance of the SPCT service was undertaken as part of the National Cancer Peer Review Programme, the last review cycle occurred in 2013 where the multi-disciplinary team was judged as 80% compliant.

### Leadership of service

# End of life care

- Staff felt supported by their managers. We were told that the medical director had an 'open door' policy and was very supportive. The medical director reported end of life issues to the board. The chief nurse and deputy were also seen as very supportive towards the end of life strategy by the SPCT.
- The junior staff in the trust felt supported by their ward managers and matrons, they told us they felt able to speak with about any matters they felt was a concern to them.

## Culture within the service

- Staff told us that end of life care was very important as it took place across the hospital. Staff training and involvement was essential. Staff on wards and departments spoke passionately about the end of life care provided. The provision of end of life care appeared to be high on the agenda for the whole trust. The specialist palliative care team promoted a culture of sharing knowledge and developing the skills of others.
- Staff we spoke with felt the trust had an open and honest culture.

## Public engagement

- Relatives were actively encouraged, when ready, to complete an evaluation form called care of the dying evaluation (CODE) which was accessible on the trust website. Information about this survey was given to relatives in the bereavement packs. This service was also offered via the telephone through the chaplaincy service. Carers were also encouraged to complete the carer experience evaluation form which was also available on the trust website. The feedback from CODE was monitored through the end of life committee and was used to educate and train staff.

- During the planning phase of the personalised care plan feedback was sought from two patient involvement groups. Since implementation feedback was sought via patient surveys, no results of this were available due the newness of the document.

## Staff engagement

- Staff within the specialist palliative care team felt very engaged and were able to be involved with the developments of the service. The chaplaincy team had been able to give some input into spiritual care of the new personalised care plan for the dying.

## Innovation, improvement and sustainability

- We asked the SPCT what they were most proud of, their response was that end of life care had taken a priority across the trust and change had happened. This was reflected and expressed from most staff we spoke with.
- The mortuary manager told us she was concerned about capacity within the mortuary as they had a service level agreement with the coroner's team and were able to accommodate patients from the community. This concern had been addressed and money was available to extend the mortuary further by another 20 spaces.
- We were told by the medical director, no savings were attached to end of life care, and the team had been working more efficiently with the aid of the ACP, PCP and TEP and will continue to aid efficiency within the service. Training and upskilling ward staff was important to aid the progress.

# Outpatients and diagnostic imaging

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

## Information about the service

Great Western Hospitals NHS Foundation Trust conducted a total of 540,487 first and follow up outpatient appointments between January 2014 and December 2014. Clinics in the main hospital site were held in 14 outpatient areas, outpatient clinics were also held in six community hospitals.

The main hospital site held clinics in the two general outpatients' areas known as Wren and Osprey and included rheumatology, dermatology, diabetic medicine, haematology, oncology, urology and the breast clinic. The Betjeman clinic focused on general medicine and movement. These clinics came under the trust's diagnostics and outpatients division. The separate areas for women and children's outpatients, orthopaedics and fracture clinic, audiology and Ear, Nose and Throat (ENT), cardiology, physiotherapy and ophthalmology clinics came under the responsibility of individual specialities and not under the trust's diagnostics and outpatients division. Physiotherapy, ophthalmology, rheumatology, orthopaedics and cardiology were among the most attended clinics, followed by the dermatology, general surgery and ENT. The imaging department at Great Western Hospital included nuclear medicine, computerised tomography (CT) scanning, ultrasound, DEXA scanning (Bone Densitometry), plain X-ray, and magnetic resonance imaging (MRI).

During the inspection we visited the two general outpatients' areas, the orthopaedic, fracture clinic, ophthalmology, ENT, dermatology, Betjeman clinic, women's clinics, cardiology and phlebotomy clinics. We

also visited the diagnostic imaging departments, the anti-coagulation service, and pathology service. We spoke with 43 patients and relatives or carers attending the hospital for a variety of outpatients and diagnostic imaging procedures. In addition we spoke with 47 members of staff, including managers, heads of service, doctors, nurses, healthcare workers, radiographers and radiologists, administrators, receptionists and members of the health record team. We also visited the outpatient booking office.

Before and after our inspection, we reviewed a range of performance information about the trust, from the trust, the clinical commissioning groups (CCG), and other stakeholders. We also looked at comments received by the CQC from people who had used the service and the NHS Choices website. We observed interactions between patients and staff and inspected the environment where services were provided.

# Outpatients and diagnostic imaging

## Summary of findings

We judged outpatients and diagnostic imaging services as requiring improvement within the safe, responsive and well led domains.

The service was caring. Patients were positive about the way staff treated them and we saw staff working hard to meet the needs of patients.

There was inconsistency of approach and processes across outpatients in regards to infection control and safety checks with a variance in safeguarding and mandatory training compliance. There was inconsistent clinical governance. This meant the trust could not be assured that safe, effective care was being provided in this service.

Within diagnostic imaging there was innovative work and excellent multidisciplinary work both within and outside the hospital.

Many staff in outpatients told us the trust was reactive rather than proactive. There was a risk that equipment failure in diagnostic imaging and ophthalmology could result in delays in patients receiving treatment. There were backlogs in some specialities that meant delays in some patients getting timely treatment.

## Are outpatient and diagnostic imaging services safe?

Requires improvement



Within the outpatients and diagnostic imaging services, we judged safety as requiring improvement. We saw learning from incidents but there was not a consistent method of cascading learning. This meant learning from incidents or safety varied across the services. There was a risk of aging equipment in diagnostic imaging and in ophthalmology failing with equipment not being replaced and the risk of patient data being lost. The process for checking equipment, medication and cleaning was not consistent.

Patient's records were sometimes missing before an appointment and when this happened doctors could refuse to see the patient.

There was a variable level of compliance with mandatory and safeguarding training. In safeguarding we noted that only 80% of those requiring level 2 training were compliant.

There were nursing staff vacancies, existing staff were offered extra hours, if nursing staff were unavailable clinics could be cancelled.

### Incidents

- There were 265 incidents reported for the diagnostic imaging service and the outpatient clinics for the three months prior to our inspection. Of these incidents 150 were managed by the outpatients and diagnostic imaging division. The remaining 85 incidents in outpatient clinics came under the specialities of women and children, orthopaedics and fracture clinic, audiology and Ear, Nose and Throat (ENT), cardiology, physiotherapy and ophthalmology and were managed within the three other trust divisions of unplanned care, scheduled care and women and children's. The majority of incidents were categorised as 'appointments and records' followed by medication errors and procedures. There had been three IRMER (Ionising Radiation (Medical Exposure) Regulations 2000 IRMER incidents, where patients had been exposed to ionising radiation to an extent greater than intended. These radiation incidents were reported to the Radiation Protection Adviser then to the Radiation Protection Committee. This committee including a trust executive with

# Outpatients and diagnostic imaging

responsibility for radiation safety reported to the trust chief executive. As a result staff used a clinical imaging IR(ME)R operator checklist entitled 'Have you 'paused and checked'? We saw posters displaying this message in the diagnostic imaging department as an aide memoire.

- Staff had access to an online reporting form and staff we spoke with told us they were confident using it. The team considered that staff may not be reporting all incidents. A few staff told us that they did not receive feedback on the incidents they reported. Staff told us of learning from incidents with practice changing as a result.
- One Never Event and two serious incidents were reported for the outpatients and diagnostic imaging services between March 2014 and April 2015. The Never Event was a wrong site surgery; one of the serious incidents was a fall and the other serious incident a health care acquired infection (HCAI). Incidents were reported under the division they were in for the trust. Incidents reported to the diagnostics and outpatients division were adequately investigated and we saw evidence of action plans and learning from incidents. For example, after the wrong site surgery the dermatology operative procedure was amended to comply with the WHO (World Health Organisation) Surgical Safety Checklist, and staff were trained to use it. Staff we spoke with in the dermatology department were aware of this and were using it. Another example of learning occurred as a result of a patient slipping and falling in outpatients whilst wearing socks. As a result laminated notices were put up and staff reminded patients not to walk without shoes on after being weighed.
- Learning was disseminated in a variety of ways across the outpatient areas. Some staff received informal updates from medical staff, whilst other staff had daily safety briefings or 'huddles', communication files, and minuted monthly team and clinical governance meetings. There was a risk that some staff did not receive learning with an unstructured approach.
- Incidents were discussed in monthly clinical governance meetings held in the pathology, radiology and cancer services clinical teams. The nursing staff on Wren, Osprey and Betjeman also discussed incidents in their monthly team meetings. These meetings and meetings

held by the specialities running their own clinics reported to the divisional directors. The divisional director then reported to the divisional monthly meeting that fed into the Patient Quality Meeting reporting to the trust executive committee. For example, we saw evidence that incidents reported in orthopaedic clinics, ENT clinics and ophthalmology clinics were reported in the planned care division.

- All staff we spoke with in the diagnostic imaging department understood their responsibilities in raising concerns and recording safety incidents and near misses. There were 16 incidents reported for diagnostic imaging in the three months before our inspection.

## Duty of Candour

- The 'Duty of Candour' requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient and any other 'relevant person' within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred. The principles aim to improve openness and transparency in the NHS.
- Most staff were aware of the Duty of Candour and the responsibilities for being open and transparent with patients. Some staff told us they were booked to have training on the duty of candour. The policy was available on the trust intranet. We saw in one incident that a meeting had been offered but declined by the patient.

## Cleanliness, infection control and hygiene

- Most clinical areas we visited appeared clean. However, in dermatology within one clinical room we noted dust on high surfaces and dead flies on a window sill. A similar issue had been identified in another clinic area within Betjeman. This was reported within a quality and safety report and stated the concerns had been highlighted to the housekeeping staff.
- Hygiene audits and infection rates were displayed in clinical areas and reported 100% compliance. However not all staff were aware of the process for these audits, for example how they were conducted or when.

# Outpatients and diagnostic imaging

- We saw staff washing their hands between treating patients. Personal protective equipment (PPE), such as gloves and aprons, were available for staff use in all areas where it was necessary. However within one clinic we found that a batch of loose gloves on a shelf in a clinical area were three years out of date. This may have meant they were at a greater risk of perishing or breaking easily. At the entrance to clinics there were hand sanitisers, we saw staff and visitors using them.
- The waiting areas were clean in all areas we visited. We saw in some outpatient areas that green labels were placed on equipment that had been cleaned, however this was not a consistent practice across the trust. Cleaning logs in outpatient areas were also inconsistent. Some areas used a safety brief that included a daily cleanliness inspection; however, in some outpatient areas there was no available checklist to ensure cleaning was monitored. In diagnostic imaging we found department cleaning logs and evidence of regular infection control audits. The trust provided us with infection control audits for diagnostic imaging. We saw the cleaning and decontamination of reusable medical devices (including patient care equipment) policy, ratified in September 2014, this advised the cleaning methods to be used for various types of equipment. Staff told us how this policy guided the cleaning of certain equipment.
- Toilet facilities were located through the outpatient areas and diagnostic imaging departments and were clearly signposted. We looked at a sample of these and they looked clean. Housekeeping staff could be called to carry out additional cleaning as necessary.
- In ophthalmology, nurses did not have access to a surgical scrub sink required for hand washing prior to certain procedures. A portable scrub sink had been tried and the current sink did not meet national guidance for facilities required in these procedures. Following our inspection the trust showed evidence that it had authorised a new scrub sink in July 2015, the staff we spoke with had been unaware of this. This meant that patients were at risk of infection and there was a delay in providing necessary infection control measures.
- Both outpatients and diagnostic imaging had systems in place to ensure the safe and effective disposal of both clinical and domestic waste.

## Environment and equipment

- Radiology equipment was identified twice on the trust's risk register from August 2014. One entry related to the gamma camera being at risk of failure in nuclear medicine due to an aging machine with numerous areas of failure resulting in unplanned downtime. This equipment is used to image certain body parts with radiation from a tracer introduced into the patient's body. Breakdowns had occurred on average one day every six weeks. There were no clear plan to replacing this equipment, with staff reporting the delay being due to financial constraints. The second risk described a number of other key items of radiology equipment needing replacement which was being delayed until the financial year 2016/17. This meant patients could face a delay in being diagnosed and staff told us this created a backlog of patients awaiting scans when the gamma camera was out of action. Staff told us this happened however but no incidents about this had been recorded in the three months prior to our inspection.
- Ophthalmology staff told us of concerns about outdated visual fields equipment that used an outmoded electronic system to transfer patient data onto the trust electronic system. Staff were concerned that a failure of the equipment would mean patient data could be lost and treatment delayed. Staff told us this had been reported to managers and was allocated to the next years capital spending.
- In the diagnostic imaging department we saw that equipment had been checked regularly and serviced in line with published guidance and that this had been recorded. In the two general outpatient areas Wren and Osprey staff told us that a central inventory of equipment was kept and that responsibility for servicing the equipment was held centrally. The trust provided us with inventories for Wren and Osprey, we asked for audits of equipment checks. We were advised this was not available, that we would need to look at the record of each individual piece of equipment. In one clinical room in dermatology outpatients we found an oxygen valve had last been checked in 2013. In one clinic outside Wren, Osprey, and Betjeman staff told us that no equipment log was kept. This meant that equipment checks varied with audits only in some areas which provided the division with no overall assurance.

# Outpatients and diagnostic imaging

- We found the outpatient and diagnostic imaging departments had resuscitation equipment with staff knowing its location. In four outpatient clinic areas the staff shared the resuscitation equipment with a neighbouring clinic, this necessitated staff leaving the clinic to retrieve the equipment. This had not been risk assessed. One clinic had resuscitation equipment ready to use but had missed a few days of checking this equipment over the last month, the other clinics showed evidence of regular checks and being ready to use.
- We saw that personal protective equipment, such as goggles and tabards were available and access to the imaging treatment restricted when treatment was taking place. There had been one incident in the last three months where a cleaner had been exposed to radiation when they had walked into a room where the computerised tomography (CT) scanner had been 'warming up'. Since then rooms were locked during initial checks to prevent a reoccurrence.

## Medicines

- Within outpatients clinics medication was mostly stored securely and medication audits had been completed appropriately. However in one outpatient clinic prescribed items for individual patients were found in two drawers. This was highlighted to staff at the time.
- Prescription pads were securely stored in a locked cabinet. When clinicians wrote patient prescriptions, the clinic kept a log which identified the patient, the prescriber and the serial number of the prescription sheet used. This ensured the safe use of prescription pads.
- Daily temperature records for fridges storing medication were completed and contained minimum and maximum temperatures to alert staff when they were not within the required range.
- There were 35 incidents recorded on the trust's incident reporting system in the three months before our inspection related to the supply of prescribed medication in the outpatients service. Themes were around wrong patient information, incorrect amount of tablets prescribed, incorrect medication prescribed and missing, and patients having to wait for a long time for their medication. This meant there was a risk that

patients could be harmed by receiving incorrect medication. Long waits could mean delays in getting home and be uncomfortable for those patients who were unwell.

- Patients told us that prescribed medications were discussed at the clinic. There was no outpatient survey to assess the information patients received about medications.

## Records

- Clinical data for measuring performance was captured electronically. Diagnostic imaging records were electronic and stored on the hospital's computer system, which were accessible to clinical staff using individually issued secure passwords.
- Within outpatient areas, records were not always stored securely. We observed records left unattended whilst clinics were on going. Trolleys were used for transferring notes but they were not secure. This meant there was a risk of breach of confidentiality with people being able to access and read patient records and of records being taken.
- We reviewed six sets of records. All records reviewed were complete with up to date typed letters, clear treatment plans and showed patient engagement. Records were legible and up to date. There was no process of auditing patient records.
- There were eight incidents for the outpatients and diagnostic imaging division involving health records recorded on the trust's electronic incident reporting system in the three months before our inspection. These including missing notes, manual handling issues, notes not being collected and misfiled information. If patients notes were unavailable for a clinic staff told us there was a risk that the doctor would not see the patient, information stored electronically such as scanned referral letters could be accessed and printed off. Risk assessments had been completed regarding manual handling and fire safety and we saw evidence that actions had been taken to reduce risks to staff.

## Safeguarding

- Staff we spoke with were aware of their responsibilities and understood their role in protecting children. We saw flow charts in some clinic areas about whom to contact, and how to make a referral if staff had safeguarding

# Outpatients and diagnostic imaging

children concerns, these were in line with the trust's safeguarding children policy. However, information provided by the trust showed that 80% of nursing and healthcare staff in the outpatient and diagnostic imaging department had completed mandatory online safeguarding children training to level 2. In Wren, Osprey and Betjeman the band 7 nurse in post from July 2015 had identified those staff requiring training.

- The trust target for compliance in safeguarding vulnerable adults was 80%, two pieces of information provided by the trust conflicted one stating 94% the other showed 0% compliance. Staff told us that if they had any concerns about a vulnerable adult in the clinic they would contact the lead nurse for adult safeguarding. The trust's safeguarding adults' policy had been due for review at the beginning of September 2015. This meant that the trust could not be assured that staff would know how to protect vulnerable adults.

## Mandatory training

- Mandatory training included health and safety, consent, infection prevention and control, moving and handling, basic life support, safeguarding and information governance. The completion of mandatory training varied between different staff groups with an average of 84% compliance, ranging from 73% in ENT outpatients to 94% in audiology. In radiology compliance was 76% overall with 95% for the radiography administrative staff. This meant the trust could not be assured that staff had the appropriate knowledge and skills to care for patients. Some staff told us they had difficulty finding time to access a computer to undertake e learning during working hours. Two bank administrative members of staff we spoke with who had been in post for over a year had not received any training. This had recently been highlighted to the bank office by a newly appointed supervisor and mandatory training had been organised for them.

## Assessing and responding to patient risk

- There were clear procedures in place for the care of patients who became unwell.
- In the diagnostic imaging department there were emergency assistance call bells in all patient areas. Staff told us and we saw call bells being used and answered immediately. Staff we spoke with were aware of their role in a medical emergency. Staff told us and we saw

that patients waiting to be taken back to the wards after their treatment or imaging were monitored by CCTV. Staff told us they were able to observe patients this way, there was a risk staff would miss signs of deterioration in a patient visible only to those in close proximity.

- Each clinical area had a Radiation Protection Supervisor who was easily accessible for radiation advice. Staff we spoke with knew who to access for advice and to report any safety concerns. We saw a rota with names, roles and availability that staff used to access advice. The service ensured a process was used to request diagnostic imaging which followed IRMER regulations.
- Signs in the waiting areas for diagnostic imaging informed people about rooms where radiation exposure took place. The service ensured women who were pregnant informed a member of staff before being exposed to any radiation. For staff we saw this in the trust's policy for the safe use of ionising radiation and for patients in the questions they were asked before treatment.
- We saw local rules, for the administration of intra-operative radiotherapy to the breast reviewed in February 2015, for nuclear medicine reviewed in May 2015 and for X-rays reviewed in July 2015. We also saw the policy for the safe use of ionising radiation and associated equipment with reference to the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER 2000).
- Radiology staff used a clear pathway for informing referrers of unexpected serious findings, with the doctor reporting the examination notifying their secretarial team who ensured the report was delivered to the referrer. An email and record was recorded on an excel log sheet for audit purposes.

## Nursing staffing

- There was a band 7 nurse in post from July 2015 who reported they were responsible for 43 nursing and healthcare staff in Wren and Osprey outpatient areas and Betjeman clinic and the community clinics. Their responsibilities included organising the rota, ensuring staff received supervision and overseeing the day to day running of the clinics in these areas. In the last year to six months the staff in these clinics could be asked to move clinics if a clinic was short of staff. There was a clinical services manager for these staff, the phlebotomy

# Outpatients and diagnostic imaging

team, anti-coagulation nurses, transfusion nurses, the health records manager, outpatients' administration and booking centre managers. The cancer and nurse specialists were under the responsibility of a cancer nurse consultant. Nursing staff in the other outpatient areas came under the responsibility of the specialities they were working in. Staff we spoke with felt skill mix worked well across the clinics. There were many nurse led clinics which staff told us were well used but there had not been use of a staffing tool to determine numbers or skills of staff in the outpatient clinics. This meant the trust could not be assured that they had the correct number and skilled staff in outpatient clinics.

- Information provided by the trust showed there were 13.28 whole time equivalent (WTE) nursing vacancies. Staff including those in senior roles told us bank nurses were unavailable due to financial constraints. In one specialist clinic the breast clinic, staff told us that had had to cancel clinics and rebook patients by phone; this had delayed treatment by one week at the most, due to a lack of staff in this case through sickness. Staff who covered the specialist ophthalmology clinic told us they would come in on a day off to cover a clinic if short of staff. This was reflected in the most recent NHS Staff survey where the percentage of staff working extra hours was higher than the national average. There was no formal escalation process if there were concerns about a shortage of staff in outpatients. In the trust's incident plan a 'significant staff absence' that caused disruption to standard service delivery was included as a business continuity incident. Although stated in the trust's incident plan staff told us that staff absence that caused disruption was not addressed, this meant that services were disrupted and patients' treatment was delayed.
- The sickness rate in July 2015 for the nursing and health care staff in the diagnostics and outpatients division was 5%. This was comparable to the national average. Among allied health professionals and scientific, therapeutic and technical staff the sickness rate was 3.5%. Sickness among administrative and clerical staff was 4%, comparable to the national average. In one clinic staff told us there was a backlog of two weeks in GP letters being typed due to staff sickness and that there was no bank staff available due to financial constraints.

- The turnover rate for nurses was 12% and 14% for administrative and clerical staff. Administrative and clerical staff told us that there had been improvements in administrative processes and that morale had improved. Nationally the turnover rate for nurses was 8%; there was no identification by the trust as to why there was this high turnover rate.

## Medical staffing

- Medical staffing was provided by the relevant speciality running the clinics within the outpatient areas and clinics. Medical staff were of a mixed grade from consultants to junior doctors. However a lack of medical staff within ophthalmology, dermatology and haematology had meant some clinics could not be held. The numbers of doctors and grades at the trust were comparable with the national average. Within histopathology there was one vacancy. Staff described how a further vacancy within this speciality would mean the service was unable to run. We saw that from March to May 2015 locum use in histopathology ranged from 6-9%, staff told us that this had not impacted on patient care.
- There was one vacancy in diagnostic imaging with a locum covering this; we saw that this post had been advertised as a permanent post. There were induction processes for locum staff. Out of hours reporting cover was provided by an outside organisation which was audited regularly. There was on call evening medical cover in diagnostic imaging.

## Major incident awareness and training

- The trust had an incident response plan which had been ratified in August 2015 by the executive committee. The plan was informed by guidance such as the NHS Commissioning Board's 'command and control' and 'business continuity framework'. It was to inform local managers and staff how to act in the event of a major incident or one that could not be dealt with using regular operational procedures. The mandatory Health & Safety training included major incident training. Betjeman had been designated as a receiving area but there were no action cards for staff to follow in the event of a major incident.

# Outpatients and diagnostic imaging

- Staff in the laboratories were able to describe their role within a major incident. Diagnostic imaging had an action plan for their staff in the event of a major incident. However, staff we spoke with were aware of the major incident plan but not their role within it.

## Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

The diagnostic imaging team had some areas of very good practice and we saw staff working together following nationally recognised pathways. The National Cancer Experience 2014 audit reported several scores above the national rates.

Patients consent was sought appropriately. However, staff had variable understanding about the Mental Capacity Act. The cardiac rehab programme was not meeting the minimum standards.

There were low appraisal rates and some staff were experiencing minimal supervision.

### Evidence-based care and treatment

- Radiation guidelines, local rules and national diagnostic reference levels (DRLs) were available for staff references. There was an assigned radiology protection adviser and a radiology protection supervisor for each clinical area. A radiation safety survey had been completed in May 2015 to ensure compliance with the Ionising Radiations Regulations 1999 (IRR99) and the Ionising Radiation (Medical Exposures) Regulations 2000 (IRMER). The staff showed good awareness of radiation protection requirements. We saw evidence through audits that radiation exposure monitoring was up to date.
- The access and patient management policy was up to date and informed by the national access targets, as defined in the technical guidance of the national annual operating framework issued by NHS England.
- Benchmarking by the British Association for Cardiovascular Prevention and Rehabilitation (BACPR) in May 2015 found the cardiac rehabilitation failed to

meet the minimum standards for cardiac rehabilitation. The service did not offer cardiac rehabilitation to heart failure patients and the length of the programme was shorter than the national 8 week programme.

- There was a dedicated one stop breast clinic as recommended by national guidelines. However, the 2014 Breakthrough Breast Cancer Service Pledge Survey for the hospital found that a quarter of patients said they didn't have a breast care nurse or key worker and a further 7% didn't know if they had one. The National Institute for Health and Care Excellence (NICE) quality standard for breast care recommends that a clinical nurse specialist is present during appointments.
- The diagnostic imaging team had some areas of very good practice, one of which the palliative ascites drainage was highly commended by the British Medical Journal (BMJ) in 2015. Innovative practice was also seen with the introduction of the intra operative breast radiotherapy project.
- Some staff told us and we observed that it was sometimes difficult to access policies on the trust's intranet; this meant that it could be difficult to access relevant guidance for reference. Some policies were at draft stage for example the processes in the electronic patient management system used in radiology.
- We requested information on one stop clinics and were provided with information of a one stop glaucoma management clinic. When we spoke with staff, they spoke of an aim for one stop clinics in ophthalmology but that they weren't there yet. Staff told us there was a pilot for a dry eye pathway.
- The cardiac rehabilitation team was not meeting national standards. They had put forward a business plan to increase the number of sessions and fulfil criteria but we were told by staff there had not been a response from managers.

### Pain relief

- There was a pain management clinic and a rapid chest pain clinic (RACPC) run at the hospital. The RACPC provided a quick and early specialist cardiology assessment for patients with chest pain.
- Results of the National Cancer Patient Experience survey 2014 suggested patients felt the staff did enough to control pain all of the time.

# Outpatients and diagnostic imaging

- We observed a patient waiting who started to experience pain. This was well responded to staff told us they could give paracetamol to patients if they were in pain, but all other analgesics had to be prescribed before being administered to patients. We saw that pain scoring was used to identify the level of pain a person was feeling.
- The imaging department had a stock of pain relief and local anaesthetic medication for use with invasive procedures. We saw that pain relief was discussed with patients.

## Patient outcomes

- The follow up to new appointment ratio at Great Western Hospital was 1.75 in December 2014, lower than the national average. This meant that the hospital was being effective in the treatment of their patients and freed up more time to see new patients. .
- In the National Cancer Patient Experience survey 2014, the trust scored higher for care being 'excellent/very good' in lower gastroenterology, haematological and upper gastroenterology than nationally.
- Outcomes in terms of performance by the trust was measured but outcomes from peoples care and treatment was not collected. The outpatient strategic service review of July 2015 reported a reduction in complaints in their quality and patient outcomes.

## Competent staff

- Staff working within a specific speciality such as cardiology or ophthalmology had training relevant to their speciality. Over the last year nursing and healthcare staff in Osprey, Wren and Betjeman had started to rotate and cover different clinics Staff told us that this initially had been daunting but that they felt well supported. However they had not completed training packages or competencies.
- We spoke with a selection of staff across outpatient clinics who told us they participated in the annual trust appraisal. Data provided by the trust showed that appraisal rates for staff working in outpatients varied from 53% compliance in ophthalmology nursing to 92% in audiology with an average of 66% across the whole trust workforce. Staff working and managing ophthalmology told us there were challenges in supporting staff and the meeting the needs of patients

in clinics. There did not appear to be consistent approach to supervision. Some staff told us they had a daily safety brief meeting and regular one to one meetings, others had ad hoc meetings.

- Some staff told us that accessing on line training had practical difficulties and that attending additional training was difficult to achieve. Staff also described having to cancel additional training due to workload pressures.
- Staff starting in diagnostic imaging had an orientation of the department's equipment with a member of staff going through the controls when a piece of equipment was new to them. Staff we spoke to who had started work at the trust within the last year had received both a local and corporate induction.
- Patients who attended outpatient clinics and the diagnostic imaging department told us that they thought the staff had the right skills to treat, care and support them.

## Multidisciplinary working

- Managers and staff working in radiology and cancer services told us of various pathways that had been developed with local clinical networks. Staff told us the pathways worked well. There were a number of joint clinics such as neurology, breast care and cardiology., We also observed a multidisciplinary breast care team meeting involving surgeons, oncologists, doctors, breast care nurses, a MacMillan nurse, a research nurse, pathologists, medical students, a radiologist, and an administrator. The meeting was structured and reviewed a variety of cases and discussed possible treatment plans.
- Radiologists met with the emergency department weekly to discuss interesting cases, and any discrepancies in diagnosis or treatment. They gave an example of the NICE head injury guidelines and data for those patients taking warfarin medication and how they had then proposed amendments to the protocols which had subsequently been ratified.
- There was good multidisciplinary working within the cardiac rehabilitation team.

# Outpatients and diagnostic imaging

- There was effective working within clinical networks where hospitals worked together to provide care. An example of this was an agreement for an out of hour's angioplasty service at two local hospitals.

## Seven-day services

- The outpatient clinics ran from Monday to Friday 8.30am to 5pm. The phlebotomy ran from 8.30am to 4.15pm. Occasional Saturday clinics had been organised and 60 patients had been seen in a session. This had been to reduce or minimise waiting times in a particular speciality.
- Diagnostic imaging operated a seven day service, with the main diagnostic imaging department open Monday to Friday 8.30am to 5pm. After this time and at weekends patients were seen in the department next to the emergency department. X rays and CT scans were available at these times.
- The ophthalmology service ran an on call 'casualty service' during the evening and at the weekend where a doctor and nurse took referrals from the emergency department, GPs and opticians.

## Access to information

- At times patient notes were not delivered to clinics on time or were missing. When this happened some doctors refused to see the patient. Staff reported this could result in treatment being delayed or an operation, procedure being cancelled. Information provided by the trust following our inspection reported 3% of notes were missing at the start of clinic.
- We reviewed systems with booking centre staff, health records staff and the administration lead for outpatients' services. This included receiving referrals, to making bookings, sending appointment letters out, preparing records for clinic, collecting data on treatment, waiting times, and doctors letters. . A patient tracking list was kept which informed the weekly waiting list action group (WLAG) chaired by the deputy chief operating officer with each speciality attending.
- Health records of all inpatients and those attending outpatients were kept in the health records library in the hospital. Other health records were stored in an external

facility. The health records library was an open library meaning staff could access health records directly. The library was reliant on staff using a case tracking system, this was not audited.

- Records were stored securely in the health records library but once out of the library they were often in public areas. Whilst close to staff, they were not always securely stored or observed.
- Within some speciality outpatient clinics staff reported clinic outcomes of outpatient consultations were not always getting back to the referring GP within 48 hours of the outpatient appointment. This was being monitored within an action plan by the administration lead for outpatient services who was working closely with heads of service and leads for outpatient clinics.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Information provided by the trust showed a varied compliance ranging from 68% to 80% for staff having completed Mental Capacity Act training. Staff we spoke with had variable understanding of the Mental Capacity Act. This meant there was a risk that patients who lacked mental capacity to make their own decisions about their care and treatment were not being adequately protected.
- Patients we spoke with said they had completed consent forms before their treatment when this had been appropriate. We were told and we saw clinicians asking for consent before starting any examination and explaining the procedure. Staff understood the need to obtain a patient's consent before undertaking procedures and for appropriate documentation to be signed.

## Are outpatient and diagnostic imaging services caring?

Good



We judged caring to be good within the outpatient and diagnostic imaging services. Patients spoke highly of the staff both in outpatients and diagnostic imaging. Some patients described their care as 'brilliant' and 'excellent'. Patients described being treated with kindness and

# Outpatients and diagnostic imaging

respect. We observed staff being courteous and friendly when responding to patient's individual needs. Patients told us they were given information in an understandable way.

## Compassionate care

- We observed patients being treated with compassion, dignity and respect. Reception staff were polite and explained what was going to happen and if there was a waiting time. In some clinics there were two receptionists close to each other talking to patients and these conversations could be overheard. Patients and staff told us there were always rooms available to talk with people privately. We saw that some staff and patients who attended the clinic had built relationships with the staff who worked there. Patients were offered chaperones.
- The majority of patients and relatives we spoke with in the clinics, diagnostic imaging department and phlebotomy were positive about their experience. . Some patients described their care as 'excellent' and 'brilliant'. Staff were described as 'really accommodating'. For example one patient described having a procedure booked that coincided with a relative coming to visit from overseas. Having told they told the consultant, the procedure was brought forward. Another example involved a patient who had travelled 25 miles for treatment. They told the staff they had another appointment the following week. The clinician arranged for that appointment to be fitted in after the first appointment so the patient did not require a return visit. Within the plaster room, staff had bought glitter to add to patients' plaster casts.
- Patient consultations mostly occurred in private rooms. Staff knocked on doors and waited before entering. However within the ophthalmic clinic there was one area where six patients could be seen at one time in six interconnecting rooms without doors. We could hear and see conversations taking place between patients and staff. Some staff were not concerned about this and found the environment beneficial for teaching purposes. Other staff were concerned about confidentiality and having to talk loudly to communicate.
- The NHS Friends & Family test was used in diagnostics and outpatients and in the cardiac rehabilitation service. In August 2015 the average score in cardiac

rehab was 5 out of 5 with 22 reviews, while in diagnostics and outpatients the average score was 4.84 out of 5 with 883 reviews. This is a single question survey as required by NHS England asking patients whether they would recommend the department to their friends and family.

- One of the waiting areas in Osprey was in a corridor which was cramped with other patients and staff.

## Understanding and involvement of patients and those close to them

- Patients we spoke with told us they felt involved in their care. They told us if they had any queries regarding appointments they would contact the details on the letter. In the three months before our inspection there were six incidents reported in relation to problems with appointments. Patients told us that they received copies of letters sent between the hospital and the GP. Patients told us that they understood when they would receive their test results and next appointment.
- Results of the National Cancer Patient Experience Survey 2014 suggested that the majority of patients at the hospital felt involved in decisions about their care and treatment or were given full information regarding potential side effects, test results or choice of treatment.
- There was written information available for patients, some provided by the trust some by external organisations. Information about safeguarding from abuse was presented in waiting areas. Staff understood when patients may need additional support to understand and be involved in their care and could access interpreters, advocates and specialists.

## Emotional support

- Staff we spoke with explained how they tried to provide support to those patients who were given distressing news. Staff told us that they had a room available for supporting patients. Patients and relatives we spoke with confirmed that they had been supported when they had received upsetting news.

**Are outpatient and diagnostic imaging services responsive?**

# Outpatients and diagnostic imaging

Requires improvement



We judged outpatients and diagnostic imaging services as 'requires improvement' for the responsive domain. Waiting times varied, and there was no data collected by the trust on the percentage of patients waiting over 30 minutes to see a clinician.

There were challenges in meeting national performance indicators with some breaches in performance. There were backlogs in ophthalmology, dermatology and rheumatology and some delays in diagnostic imaging. Action to address this was not always timely. Learning from complaints was inconsistent across the services.

The management of appointments for the majority of clinics was being looked at through a trust booking centre action plan.

There were no patient forums to seek patients' views. There had also been medical vacancies in some specialities which had had an impact on being able to run enough clinics to meet patient demand.

Patients were reminded to attend by text messages or phone messages. There was sufficient seating within the outpatient clinics, patients felt informed and staff apologised for any delays.

## Service planning and delivery to meet the needs of local people

- Patients told us they were allocated enough time with clinicians when they attended their appointments and that their appointments were not rushed. Patients reported that clinicians were well informed about their medical history.
- Missing or incomplete notes meant that that staff did not always have access to correct, contemporaneous patient records. Waiting times varied. Some patients we spoke with were called in on time others expected to wait for up to an hour. In clinics we saw staff update boards informing people of the waiting times and talk with patients about possible delays to the running of clinics. We observed good patient flow in the main areas

of most clinics. The trust did not collect data to allow them to monitor and address the percentage of patients waiting over 30 minutes to see a clinician, or when clinics started late.

- Patients told us there was sufficient car parking available and it was close to the hospital. There were volunteers at the hospital entrance who guided visitors and the clinics were well signposted.
- Patients were able to access drinks and were offered them by staff. There was comfortable seating and play areas for children with toys.
- We saw in the outpatients improvement plan part of the transformation plan there was a work stream looking at how to improve the experience for patients and the systems for managing appointments in outpatient clinics.
- Patients received text reminders or phone messages about impending clinic appointments. This meant patients could respond and rebook if they were unable to attend. Staff told us that this has become more popular, the DNA rate had reduced by 1%. Patients attending ophthalmology appointments received letters with bold larger print on yellow paper.
- Some patients told us and staff in the booking centre confirmed that the postal system used by the booking centre could possibly send two cancellations and two rebooked appointment in one envelope. Staff told us post was sent through an external agency via second class mail. Including multiple letters in one envelope was reported as being more economical. The system also had difficulty in enclosing a leaflet. As a result of the second class post, patients and staff told us they had missed appointments.

## Access and flow

- The trust's outpatient booking centre was responsible for the centralised booking and management of new outpatient appointments. The booking centre took referrals as a mixture of paper and electronic via Choose and Book (approximately 30%). Staff took on average 20,000 telephone calls a month from internal and external callers' requiring information on new patient clinic appointments. Referrals were entered onto the Patient Administration System (PAS). Some referrals were sent to the specialities, these being women and

# Outpatients and diagnostic imaging

children, ENT, endoscopy, ophthalmology, orthopaedics, surgery, cardiology and dental who were also responsible for their own performance and staff teams. The consultants aimed to triage the referrals within 48 hours. The administration lead for outpatient services produced appointment slot issue (ASI) reports weekly to identify how many patients were waiting for the first appointment, how long they had waited and the longest waiting time.

- Managers, administrative leads and booking centre staff told us that there had been challenges in meeting the demand for patients to be seen in clinics for various reasons. Staff told us some of the challenges included clinic cancellations by doctors within six weeks, 4 to 5 % of clinics were cancelled, patient DNAs 8%, and funding for additional clinics. Information requested and provided by the trust following our inspection showed that 795 clinics in total had been cancelled in the months of July, August and September 2015. This meant that patients had delays in treatment.
- The trust had developed a performance dashboard to show how they were performing against national targets. This linked in with the trust's transformation project and specific areas of work they were addressing.
- Hospital Episode Statistics (HES) for January 2014 to December 2014 showed 540,487 first and follow up appointments in total. The data showed that the hospital's follow up to new appointments was lower than the England average and fell within the midrange compared to all trusts. The 'did not attend' rate (DNA) was higher at 8% than the national rate of 7%.
- The trust provided a referral to treatment (RTT) report for performance from March 2015 to June 2015 with the trust target for 95% of non-admitted patients starting consultant-led treatment within 18 weeks of referral and that 92% of incomplete pathways should start consultant-led treatment within 18 weeks of referral. In January 2015 the RTT dropped to 90% and in February 2015 the incomplete pathways were down to 85%. The worst performing RTT by specialities were in rheumatology and dermatology. There had been an action plan to address this with the recruitment of a rheumatology doctor and advertisement for a dermatologist.
- The admin operational lead who worked on the outpatients' strategic service review and improvement plan had been chairing the weekly patient treatment register meeting (PTR) which reported on appointment slots across specialities. This group was replaced two weeks before our inspection by a weekly Waiting List Action Group (WLAG) held with each speciality by the deputy chief operating officer but with no input from those involved in the improvement plan.
- On the risk register for outpatients was the stress echo service with demand outweighing the capacity with one cardiologist who undertook this test. This was breaching the six week diagnostic target. This service came under the cardiology speciality which was not managed by this division but the unscheduled care division.
- Cancer waiting times to be seen by a specialist within two weeks of an urgent GP referral at trust level were 93.9% worse than the England average of 94.7%. However, the percentage of people waiting less than 31 days from diagnosis to first definitive treatment was 100% better than the England average of 98.8%.
- The trust generally performed better than the national average for people waiting for a diagnostic procedure with a low proportion of people waiting for more than six weeks. However the six week diagnostic targets were not met in June and July 2015 with pressure areas being general anaesthetic (GA) Magnetic Resonance Imaging. The trust performed at 5%, below the national target of less than 1% of patients waiting over 6 weeks to achieving the six week waiting time for ultrasound scans. This meant that patients could experience delays in a diagnosis
- Within dermatology, there was a delay in providing outpatient appointments due a lack of medical staff and rheumatology clinic lists had been closed to new patients until September 2015. The specialities of dermatology, ophthalmology and haematology had vacancies we saw these had been advertised. Recent recruitment in rheumatology meant the clinic could take new patients. There had been occasions when clinics were cancelled at short notice due to a doctor's leave; a new process of staff having to give six weeks' notice had been introduced to reduce the likelihood of this occurring.
- Ophthalmology clinic lists had also been closed to new patients for periods of time. Managers told us there were 22 patients within ophthalmology on hold, meaning

# Outpatients and diagnostic imaging

they had not had an initial appointment. Three of these patients had been waiting from the month of March 2015. Information provided by the trust from April 2015 to September 2015 showed a total of 528 ophthalmology patients with overdue and un-booked follow up appointments. This meant these patients were waiting to be assessed and treated. We saw in a risk register report that the follow up for age related macular degeneration (ARMD) patients should not exceed five weeks but since June 2015 had increased to eight weeks due to a lack of capacity..

- Staff from the cardiac rehabilitation team visited patients on the ward and then rang patients after discharge from hospital inviting them to a programme in a community centre or offered a programme at home with a heart manual, file and telephone support.
- Staff working in orthopaedics told us about a pilot virtual fracture clinic operating until November 2015 where all fracture clinic patients needing reviewing in 72 hours were phoned. They contacted 24 patients a day and then arranged follow up in an appropriate clinic. They were able to liaise with multidisciplinary colleagues as necessary. This had meant that the extra two to three clinics they used to put on were no longer required and this had freed up time for other appointments.

## Meeting people's individual needs

- Staff told us that those attending an outpatient clinic for the first time the staff expected those patients with additional needs to have been highlighted by their GP and/or a relative or carer. They also expected that a carer would accompany and assist the patient. There was a team staff could contact for advice for those patients with a learning disability. The OWLS (Outpatient Welcome and Liaison Service) a service offering support for those with dementia when visiting hospital for appointments was not currently operating. If a patient appeared vulnerable staff told us they would assist them. The electronic appointment system was not able to alert staff to patient's individual needs.
- Staff told us they had access to a translation service should they need it. This meant that patients, for whom English wasn't their first language, could engage fully in their consultation. However there were no signs or leaflets available languages other than English

- Patients with mobility difficulties were prioritised, and in main outpatients there were higher chairs for people to use if needed. However for patients with bariatric requirements staff told us the doors to the clinic rooms were too narrow. This was on the trust risk register. Patients with bariatric requirements were seen in the Betjeman clinic, or in the dermatology recovery area or in Wren clinic. We saw from evidence provided by the trust that a costing for couches had been received in June 2015 and that a request for a quote to widen doors in these areas had been submitted in June 2015 to the organisation who managed the infrastructure of the hospital. The lack of bariatric equipment had an impact on patient care. We identified one incident when a patient was unable to be examined due to the lack of a hoist for patients with bariatric requirements.
- Patients and staff told us that there were times when patients waited for long periods for hospital transport. This transport was provided by another organisation. Information provided by the trust following our inspection showed that for the months between April and June 2015 for those with pre booked hospital transport 62% waited for 60 minutes or less.
- We saw that patients were offered refreshments and that drinks were accessible nearby.

## Learning from complaints and concerns

- Information on how to complain was available in the waiting areas with details of the Patient Advice and Liaison Service (PALS). The PALS office was based on the ground floor near the main entrance. Patients we spoke with knew how to make a complaint.
- Over a five month period before our inspection there were seven complaints in relation to diagnostic imaging, all differing in nature. There were 55 complaints for outpatients, with the main themes being delays and communication.
- Complaints related to diagnostic imaging were discussed at their clinical governance meetings. Complaints for outpatients in Wren, Osprey and Betjeman were discussed in the nursing team meetings. The themes of complaints were seen within work streams in the outpatients' improvement plan and were

# Outpatients and diagnostic imaging

discussed in the team meetings held for staff working Osprey, Wren and Betjeman. However learning from complaints in the other outpatient clinics were inconsistent.

- There were no patient forums to seek patient's views.

## Are outpatient and diagnostic imaging services well-led?

Requires improvement



In order for the outpatient and diagnostic imaging services to be well led, we judged improvement was required. There was not a clear vision within outpatients, and the trust's values were not widely known by the staff. There was a piece of dedicated work on streamlining the outpatient process and a recent strategic review but there was not a consistent strategy across the outpatients' clinics and specialities. There were specialities working in silos with limited working on the outpatient processes.

Diagnostic imaging had a clear governance process and were focused on providing a good service to their patients. For outpatient staff governance arrangements were inconsistent. Not all staff felt listened to by the trust.

Staff felt financial pressures impacted on the trust's ability to meet patient's needs. Risks and issues were not always dealt with in a timely way or appropriately and the views of both patients and staff were not actively sought to improve outpatients' services.

### Vision and strategy for this service

- The trust's values as shared with the CQC were not widely known by the staff we talked with. A piece of dedicated piece of work towards streamlining the outpatient process had begun. However there did not appear to be a robust trust level strategy to bring all the specialities for the outpatients' service together to improve performance.

### Governance, risk management and quality measurement

- Staff in diagnostic imaging had monthly imaging clinical governance steering group meetings in which they discussed learning from incidents and complaints, policies, clinical issues and trust information. This

meeting then linked into the imaging sub divisional meeting and then the diagnostics and outpatients managers meeting. The band 7 nurse leading Wren, Osprey and Betjeman held a daily safety brief with staff and monthly meetings where information was shared. Other nurses in the speciality outpatient clinics had different arrangements, ranging from informal un-minuted talks to regular minuted meetings.

- A performance dashboard had been developed and formed part of the outpatients services strategic service review. There were improvement plans for outpatients, consisting of 19 work streams. Ten of the work streams had completed between 81-100% of their actions. The work streams included patient management file to ensure no patient was waiting longer than their due date for an appointment, short notice clinic cancellations, new to follow up ratio, clinic outcomes and coding, transport, data quality, estates, booking management and clinics.
- Specialities such as cardiology, ophthalmology, women and children, ENT, endoscopy, orthopaedic, and surgery came under what was described as 'the villages'. Here staff were managed within the speciality. Nursing and healthcare staff working in Wren, Osprey, and Betjeman
- A second risk on the risk register, identified in August 2014, was the potential failure of a piece of equipment from diagnostic imaging, the Gamma camera, which needed replacing due to its age. On the risk register other key pieces of equipment were identified as needing replacement in the financial year 2015/16, it was recorded that due to financial constraints this would be delayed until at least the financial year 2016/17.
- The third risk identified were doorways not being wide enough for patients with bariatric requirements. We were told that patients with bariatric requirements would be seen in Betjeman clinic, in Wren clinic or in the dermatology recovery area. We saw evidence provided by the trust that costing for couches had been received in June 2015 and that a request for a quote for door widening had been submitted in June 2015. There was no planned date as to when these purchases and work would commence. This meant that there was still a risk that the needs of patients with bariatric requirements may not be met.

# Outpatients and diagnostic imaging

## Leadership of service

- Many staff we spoke with described the trust leadership as reactive and not proactive or forward thinking. Most staff had not heard of the 'In Your Shoes' scheme described in the trust's presentation to the CQC and some said they would like the trust team to come and spend some time shadowing them.
- Staff in diagnostic imaging had strong clear leadership.
- The separate 'villages', the various systems of working under three potential divisions made ownership and implementation of the improvement plan in outpatients more challenging. There were aspects of the 'transformation, improvement plan' that we were told had not been shared with staff. Some staff felt supported in their outpatient teams others felt support was ad hoc.

## Culture within the service

- Nurses, healthcare assistants, doctors and staff in diagnostic imaging and outpatients we spoke with were focused on providing a good service to their patients. They aimed to provide a better service for their patients.
- A few members of staff approached us directly as they wanted to share their thoughts about issues they felt had not been addressed by their managers. These were business cases or proposals that they believed would benefit patients and ensure national guidance was being followed. Some staff spoke of not feeling listened to.
- However most staff told us they felt the culture was open at the hospital but some staff felt that financial constraints were the primary concern for managers.
- Many staff we spoke with told us the trust had a focus on finances and this they told us impacted on the delivery of care. Staff across the service told us that they were not allowed to have bank staff this impacted on patient care in delays in appointments going out, and clinics having to be rescheduled. Staff believed delays in recruitment and business cases to develop services in line with national guidelines were postponed due to financial reasons. We saw documents that stated 'we must find better ways of working, because there isn't money for more staff' and stated savings targets across

all outpatient. Aging equipment that was due to be replaced we were told by managers could not be replaced due to finances but was at risk of complete failure and was out of action on a regular basis this delayed diagnoses for some patients.

## Public engagement

- Patient's views were captured on Friends and Family comment cards. There were no patient forums running in outpatients or diagnostic imaging. There were volunteers who worked in the hospital but none were present in outpatients during our inspection. There were plans to restart volunteer engagement and support in the departments.

## Staff engagement

- Some staff spoke of a gap between front line staff and the senior managers. Some open sessions with managers had been facilitated during the working day but there had been very limited attendance by clinical staff. We were told a comments box had been introduced for staff suggestions a month before but we did not see this.

## Innovation, improvement and sustainability

- Staff and managers spoke of 'growing their own staff', developing staff and encouraging progression. Many staff told us that there had been improvements in the trust over the last six months to year and that they enjoyed working at the hospital. Staff spoke of morale improving and that some services were more sustainable than before.
- The diagnostic imaging department had some innovative practice and was well regarded academically. One piece of innovative work was the palliative ascites drainage which was highly commended by the British Medical Journal (BMJ) in 2015. Another was the introduction of the innovative intra operative breast radiotherapy where a single dose of radiation is given during surgery to remove breast cancer.
- The improvement plan for outpatients from March 2015 with its 19 work streams together with the strategic service review from July 2015 set out the actions needed to address the challenges facing the outpatient clinics.

# Outstanding practice and areas for improvement

## Outstanding practice

The diagnostic imaging team had some areas of outstanding practice, one of which, the palliative ascites drainage, was highly commended by the British Medical Journal (BMJ) in 2015. Innovative practice was seen with the introduction of the intra operative breast radiotherapy project.

In the critical care unit we were given examples of staff 'going the extra mile' for their patients, including a patient attending a family wedding in London, with transport being arranged by the unit and staff escorting the patient for the day.

The consultants provided specialist pre and post pregnancy counselling and support service to women. This and other specialist clinics developed to manage high risk pregnancies had been recognised as best practice. The lead consultant had won an All-Party Parliamentary Group Maternity Services Award during 2011. This service style had since been adopted by other Maternity Services across the country and show-cased at Harvard, USA.

The midwives successful audit and interdepartmental training to prevent cerebral palsy in pre- term babies born at the hospital.

## Areas for improvement

### Action the hospital MUST take to improve

Importantly, the trust must:

- Ensure staff receive up to date safeguarding, mandatory training appraisals and training on the Mental Capacity Act to meet trust targets.
- Improve governance processes to demonstrate continuous learning, improvements and changes to practice as well as board oversight and assurance.
- Ensure there are sufficient numbers of midwifery staff to provide care and treatment to patients in line with national guidance.
- Ensure sufficient trained and competent nursing staff at all times.
- Ensure effective infection prevention and control measures are complied with by all staff.
- Ensure safe storage of medicines including intravenous fluids.
- Improve the access and flow of patients in order to reduce delays from critical care for patients being admitted to wards and reduce occupancy to recommended levels.
- Review nurse staffing levels and skill mix in the emergency department (ED), including children's ED, the ED observation unit and minor injury units, using a recognised staff acuity tool.
- Take steps to ensure there are consistently sufficient numbers of suitably qualified skilled and experienced nurses employed to deliver safe, effective and responsive care.
- Ensure all staff who provide care and treatment to children are competent and confident to do so.
- Make clear how patients' initial assessment should be carried out by whom and within what timescale within the ED.
- Monitor the time self-presenting patients wait to be assessed and take appropriate action to ensure their safety. This must include taking steps to improve the observation of patients waiting to be assessed so that seriously unwell, anxious or deteriorating patients are identified and seen promptly.
- Ensure that clinical observations of patients are undertaken at appropriate intervals so that any deterioration in a patient's condition is identified and acted upon.

# Outstanding practice and areas for improvement

- Risk assess and make appropriate improvements to the design and layout of the emergency department observation unit to reduce the risk of patients harming themselves or others.
- Clarify the use of the observation unit setting out its purpose, admission criteria and exclusion criteria to ensure that patients admitted there are clinically appropriate and receive the right level of care.
- Ensure best (evidence-based) practice is consistently followed and actions are taken to continually improve patient outcomes.
- Ensure chemicals and substances that are hazardous to health (COSHH) are secured and not accessible to patients and visitors to the wards.
- Ensure sharps bins are used in accordance with manufacturer's guidance to prevent the risk of a needle stick injury.
- Ensure staff members are aware of the risk of cross infection when working with patients with isolated infectious illness.
- Ensure risk assessment tools in place to identify risks of thrombosis, pressure damage, moving and handling, nutritional and falls are consistently completed and appropriate action taken.
- Ensure National Early Warning Scores used to identify from a series of observations when a patient was deteriorating are appropriately actioned when high indicator scores were seen.
- Ensure the management of patients on medical wards with mental health issues are fully considered.
- Ensure appropriate review and action are undertaken when Deprivation of Liberty Safeguards had been put in place.
- Ensure consistently comply with the mental capacity act. Ensure all appropriate surgical patients have their mental capacity assessed and recorded to ensure consent is valid, and the hospital is acting within the law.
- Ensure patients records are fully completed and provide detailed information for staff regarding the care and treatment needs of patients.
- Ensure provision of single sex accommodation.

- Ensure all areas of the premises and equipment are safe and secure, and patient confidential information is held securely at all times.
- Ensure patients being admitted overnight to the day surgery unit have appropriate facilities which meet their needs, maintains their privacy and dignity, and reflects their preferences.
- Provide a responsive service to reduce waiting times and waiting lists for surgery procedures. Theatre efficiency, access and flow, delays, transfers of care, and bed occupancy must be improved to ensure patients are safely and effectively cared for.

## Action the hospital **SHOULD** take to improve

In addition the trust should:

- Continue to take steps to improve patient flow, reduce overcrowding and reduce the time that patients wait in the emergency department.
- Take steps to ensure that patients attending the emergency department and minor injury units are greeted and receive care and treatment in areas which are conducive the exchange of private information their privacy and dignity.
- Clearly set out the objectives of initiatives designed to improve patient flow and the protocols which guide their use so that there is consistency of staff practice and engagement, and their effectiveness can be evaluated.
- Review shower and bathing facilities to ensure safe access to appropriate shower facilities.
- Consider access to toilets in bays for patient who have visual or mobility issues to ensure a safe and clear route to the bathroom.
- Ensure topical medicines stored in sluices and used for multiple patients do not pose a risk of cross infection to patients.
- Have a consistent approach to recording patient allergies, including medicine allergies and intolerances.
- Undertake a review of discharge medicines practice to ensure patients are not left waiting.
- Consider appropriate action to ensure future cover for the medical lead for the outlier team.

# Outstanding practice and areas for improvement

- Consider the implementation of a pain assessments tool for patients with limited communication.
- Review therapy access at the weekend to ensure patients receive the care they need.
- Review the systems in place for the sending of letters to GP's in some areas to ensure their safety.
- Review communication from ward to board to ensure staff are aware of the systems in place above divisional level.
- Ensure surgery staff are reporting incidents in accordance with policy and given time to do so.
- Ensure patient records in surgery services accurately report data. The use of question marks to replace knowledge of, for example, if a patient had eaten their meal, should not be permissible.
- Ensure the audit results of providing patients with an assessment for venous thromboembolism are accurate.
- Ensure arrangements in place to replace aging diagnostic imaging equipment identified as at risk of failure
- Put systems and processes in place to ensure equipment is regularly checked
- Accurately identify backlogs in patients requiring outpatient appointments
- Undertake a staffing review of nursing and administration staff within the outpatients departments
- Consider the development of patient forums for outpatients and diagnostic imaging
- Ensure mortality and morbidity reviews are comprehensively recorded and lessons learned are shared locally and throughout the trust.
- Ensure medical equipment and devices are replaced when scheduled within critical care
- Record non-compliance with the Core Standards for Intensive Care Units (2013) in critical care on the risk register to ensure continued focus on compliance.
- Review the security of confidential patient records in critical care to ensure they are safe from removal or the sight of unauthorised people.
- Develop an appropriate clinical audit programme in place so that patient care can be assessed, monitored and improved.
- Review the provision of the critical care outreach team service, to ensure patients can receive timely critical care input in the wider hospital environment.
- Review the role of the clinical nurse educator within critical care to ensure adequate time and resources are given to this essential post in line with best practice and the Core Standards for Intensive Care Units (2013).
- Ensure critical care is included in major incident exercises.
- Review the provision of dietitians and speech and language therapists to ensure critical care patients are adequately supported.
- Review its policies and procedures for critical care step down, handover and discharge to ensure patients are adequately supported at all stages.
- Review the provision of care to patients in critical care to ensure compliance with National Institute for Health and Care Excellence (NICE) guidance 83 in relation to some parts of patient rehabilitation, including discharge advice and guidance and follow-up clinics.
- Review the process for HIV screening and results feedback in the critical care unit to ensure patients are kept informed.
- Ensure critical care strategies and future plans are approved and part of the overarching strategy of the division
- Ensure all equipment has in date maintenance checks
- Improve the maternity and trust IT systems to remove duplication and increase accessibility.
- Ensure gynaecology inpatients do not have their elective inpatient treatments cancelled as a result of other medical and surgical patients admitted to Beech ward.
- Review actions to recruit and maintain specialist gynaecology nurses.

## Requirement notices

### Action we have told the provider to take

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

#### Regulated activity

Treatment of disease, disorder or injury

#### Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

The provider had not taken appropriate steps to ensure that the care and treatment of service users

(b) met their needs

Surgery services were not meeting the referral to treatment times for all of the surgical specialties with the exception of ophthalmology. Theatre utilisation, bed occupancy, and access and flow for patients was sub-optimal.

a) be appropriate,

b) meet their needs

Patients in the critical care service were not discharged in a timely way from the unit onto wards when they were ready to leave. The bed occupancy exceeded recommended levels too frequently.

#### Regulated activity

Treatment of disease, disorder or injury

#### Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

10(2)(a)

The Medical Assessment Unit (Linnet) was seen to be providing mixed sex accommodation. This meant that male and female patients were in the same four-bedded bay.

#### Regulated activity

#### Regulation

## Requirement notices

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

12 (1) The provider did not provide care and treatment in a safe way:

- Self-presenting patients in ED did not always receive prompt initial assessment (triage). 12 (2) (a)
- Risks to patients were not always mitigated because staff did not follow plans and pathways. Patient observations were not consistently undertaken with the required frequency to ensure that any deterioration in a patient's condition was identified. 12 (2) (b)
- The location, design and layout of waiting rooms did not ensure that waiting patients were adequately observed 12 (2) (d)

The location, design and layout of the emergency department observation unit was not suitable for the care of patients with mental health needs who presented challenging behaviour or were at risk of harming themselves and/or others. 12 (2) (d)

Regulation 12 (2)(h)

Assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are health care associated

Chemicals and substances that are hazardous to health (COSHH) were observed in areas that were not locked and therefore accessible to patients and visitors to the wards. Cleaning materials including chlorine tablets were in the sluices, which were unlocked.

Sharps bins were in place throughout the medical wards and departments for the safe disposal of used needles and other sharp equipment. However, we observed these were not used in accordance with manufacturer's guidance as they were not consistently closed when in use and some were over two thirds full and still being used. This meant staff were at risk of a needle stick injury.

Staff members were not all aware of the risk of cross infection when working with patients with isolated infectious illness. We observed a staff member moving from an isolation area to ward to kitchen without removing an apron or washing hands. This did not

## Requirement notices

prevent or control the spread of infection. We established the staff member had received infection control training. The audit scores for this ward did not include an observation of staff practice. The ward manager's review of wards does not include an observation of staff behaviour.

Regulation 12(2)

(a) assessing the risks to the health and safety of service users of receiving the care or treatment.

(b) doing all that is reasonably practicable to mitigate any such risks.

National Early Warning Scores used to identify from a series of observations when a patient was deteriorating were not always appropriately actioned when high indicator scores were seen. The hospital used National Early Warning Scores to identify from a series of observations when a patient was deteriorating. The scores gave criteria for action and instructions for staff to follow. Two patient records showed National Early Warning Scores not always actioned and no explanation provided for actions not seen to be taken. We saw that in several records the MUST nutritional screening tool was not completed, a falls risk assessment was completed but with no associated care plan, the risk assessments for bed rails did not correspond with the scoring indicator but no rationale was provided for the decision to use bed rails. We saw that when a fluid and food record was indicated these were not consistently completed and reviewed to establish any risks.

The management of patients on medical wards with mental health issues was not fully considered. For patients with a high risk of attempting suicide consideration of ligature risks on the ward were not recorded.

We saw that an assessment of a patient had taken place in the emergency department to identify suicide risks but no ward-based assessment had been completed and no close observation was in place to reduce this risk. Staff did not have a ward management plan or staff training in place for ligature risks.

Deprivation of Liberty Safeguards had been put in place; appropriate review and action were not always

## Requirement notices

undertaken. We looked at four Deprivation of Liberty safeguards forms, which had been completed to ensure the patients safety. Two of the four forms had expired without review taking place. This meant that staff might have deprived those patients of their liberty without legally being in a position to do so. No tracking facility was in place to ensure that the safeguards were reviewed and updated as necessary.

The trust used Treatment Escalation Plans (TEP) to identify the patient's choices for resuscitation. We saw that when a patient was identified as not having capacity to be included in the making of the decision to resuscitate the appropriate assessments under the mental capacity act were not consistently completed. This meant that the patient's best interests might not be appropriately considered in the decisions being made. We saw this on Jupiter ward and Neptune ward.

### Regulation 12: Safe care and treatment

12(2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include:

g) The proper and safe management of medicines

Intravenous fluids were not being stored securely in the critical care unit.

## Regulated activity

Diagnostic and screening procedures  
Treatment of disease, disorder or injury

## Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

The provider had not ensure all premises and equipment used by the service provider was:

(a) secure

The day surgery unit was unsecure and unauthorised people had access to the premises and equipment.

15(1) All premises and equipment used by the service provider must be:

## Requirement notices

(a) clean

15(2) The registered person must, in relation to such premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used.

Equipment and environmental areas in the critical care unit were not thoroughly cleaned. Checks were in place after cleaning but these failed to identify inadequate hygiene and cleaning standards

### Regulated activity

Diagnostic and screening procedures

Treatment of disease, disorder or injury

### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

17 (1) Systems and processes were not established and operating effectively to ensure compliance with the requirement in this part of the Act.

The service risk register in the Emergency department did not reflect the multifactorial risks to safety and quality.

Measures to reduce or remove identified risks were not introduced in timescales that reflected the level of risk.

17 (2) (b)

The audit system was not effective; the service was not acting promptly or consistently in response to results of national audits. 17 (2) (f)

There was limited evidence that the views of people who used the service were actively sought and acted upon.

17 (2) (e)

Regulation 17(2)(c)

Maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

Records were not fully completed and did not provide detailed information for staff regarding the care and treatment needs of patients. The care plans were generic

## Requirement notices

pre-printed task-focused lists that staff ticked and dated when they had provided care to patients. These did not provide detail on the individualised care needs and requirements of patients. For example, the records for personal care did not detail the patient's preference or how much help they needed.

### Regulation 17(2)(b)

Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

The effectiveness of governance systems was not evident in some areas. We saw that areas of concern had not been identified and actioned. For example, the management of the Deprivation of Liberty Safeguards did not have systems in place to identify when the safeguards were about to expire. Shortfalls in the completion of Treatment Escalation Plans and mental capacity assessments affected patients' choices and decisions. The trust had put systems in place to develop training however, in the interim, it was evident that the systems in place did not ensure patients safety. It had not been identified that patients at risk due to mental health issues were being cared for in an inappropriate environment and that staff and patients safety was ensured.

The provider had not operated systems or processes to:

(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity, and

(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and the decisions taken in relation to the care and treatment provided.

The surgery service was not able to demonstrate effective clinical governance, continuous learning, improvements and changes to practice from reviews of incidents, complaints, mortality and morbidity reviews, and formal structured clinical audits with actions and results. For example, there had been no action evident

## Requirement notices

within clinical governance after following the National Emergency Laparotomy Audit (NELA) or recommendations from an investigation and action plan following a Never Event in surgery

17(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements of this Part.

The critical care unit did not have a governance structure. There were limited governance systems or processes in place.

17(2) Such systems or processes must enable the registered person, in particular, to:

(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services).

Regular audits and other systems and processes were not in place in the critical care unit to assess, monitor and improve services.

### Regulated activity

Diagnostic and screening procedures

Treatment of disease, disorder or injury

### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

18(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.

There were times when the critical care unit did not have sufficient nursing staffing levels for the dependency of their patients.

18(2) Persons employed by the service provider in the provision of a regulated activity must:

a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to carry out the duties they are employed to perform.

## Requirement notices

Compliance with mandatory training and appraisals within the critical care unit were below target.

The critical care unit did not have a minimum of 50% nursing staff holding a critical care award

18 (1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.

Care and treatment must be provided in a safe way. There were inadequate numbers of midwives to meet the Royal College of Obstetricians and Gynaecologists (RCOG, 2007) Safer Childbirth Minimum Standards for the Organisation and Delivery of Care in Labour. The midwife to patient ratio consistently exceeded the recommended ratio of 1:28 for safe capacity to achieve one-to-one care in labour. One to one care was consistently not achieved for all women in established labour, and the first two hours following birth. The community midwives had ante and post-natal caseloads of 1:150 which exceeded the recommended level of 1:100 (Birthrate Plus, Royal College of Midwives). The redeployment of community midwives for extended working hours resulting from using the escalation plan may have increased risks to patient care.

### Staffing

The provider had not taken appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff employed to meet the requirements of the fundamental standards. 18 (1)

Staffing levels had not been reviewed or adapted to respond to increased demand and changing needs. 18 (1)

There were not always sufficient numbers of suitably qualified, skilled and experienced nursing staff in the emergency department or minor injury units. 18 (1)

Safe levels of staffing and skill mix had not been defined in relation to caring for patients who could not be accommodated in cubicles in the emergency department. 18 (1)

## Requirement notices

There were insufficient numbers of staff employed in the children's emergency department who had received appropriate training to equip them to care for children. 18 (1)

There was an unstructured approach to nurse training and nurses did not consistently receive protected time for training or clinical supervision. 18 (2) (a)

Staff caring for patients with mental health needs who had been assessed as being at high risk of harming themselves and others had not received specialist training to equip them for this role. 18 (2) (a)

Regulation 18(1) sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this part.

Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed in all areas of the medical division.

When wards were short of staff, staff from other wards were moved to provide cover. This meant that staff numbers and skills were depleted on the staff's normal ward. The trust attempted to backfill on those wards with agency staff, but this was not always possible so those wards worked short of staff.

The provider had not taken appropriate steps to ensure that, at all times, sufficient numbers of suitably qualified, skilled and experienced staff were employed for the purposes of carrying on the regulated activity.

There were not always sufficient numbers of nursing staff on duty in the surgery division to provide safe care and to meet people's needs.

## Enforcement actions (s.29A Warning notice)

### Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

#### Why there is a need for significant improvements

#### Where these improvements need to happen

##### **Care and treatment are not being provided in a safe way for service users.**

- i. The location, design and layout of the emergency department observation unit at the above location, combined with inadequate staffing levels and staff training, presents risks to patients and staff. While these have been known risks (as identified in the unscheduled care division's risk register), measures to mitigate these risks have not been sufficiently timely or effective.
- ii. Systems to ensure accurate records were maintained in respect of patients' care and treatment were not effective.
- iii. There was a lack of assurance that nurse staffing levels had been appropriately established or that planned levels of staffing were consistently achieved to ensure that patients attending the emergency department received timely, safe and effective care and treatment.
- iv. There were insufficient numbers of staff employed in the children's emergency department who had received appropriate training to equip them to care for children. Planned staffing levels were not consistently maintained. This, combined with the design and layout of the department, presented unacceptable risks to patients.
- v. There was inadequate oversight and monitoring of staff training to ensure that staff had the right qualifications, skills, knowledge and experience to provide appropriate care and treatment in a safe way.

##### **Systems or processes have not been established and operated to ensure:**

- a. the assessment, monitoring and improvement of quality and safety of the services provided,**
- b. the assessment, monitoring and mitigation of risk relating to the health, safety and welfare of service users, and others who may be at risk which arise from the carrying on of regulated activity.**

Great Western Hospital

## Enforcement actions (s.29A Warning notice)

**c. that accurate, complete and contemporaneous records are maintained in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.**

i. The governance systems and processes in place within the trust, were not effectively operated and as such were not able to demonstrate effective clinical governance, continuous learning, improvements and changes to practice from reviews of incidents, complaints, mortality and morbidity reviews.