

# Homerton University Hospital NHS Foundation Trust

# Homerton University Hospital

## Quality Report

Homerton University Hospital NHS Foundation Trust  
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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

<b>Overall rating for this hospital</b>	<b>Good</b> ●
Accident and emergency	<b>Outstanding</b> ☆
Medical care	<b>Good</b> ●
Surgery	<b>Good</b> ●
Intensive/critical care	<b>Good</b> ●
Maternity and family planning	<b>Good</b> ●
Services for children & young people	<b>Good</b> ●
End of life care	<b>Good</b> ●
Outpatients	<b>Good</b> ●

# Summary of findings

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# Summary of findings

## Overall summary

Homerton Hospital became Homerton University Hospital NHS Foundation Trust on 1 April 2004 – one of the first 10 trusts in the country to achieve foundation status. The trust comprised a medium-sized hospital providing acute, specialist and community services to Hackney and the City of London. The trust also owned Mary Seacole Nursing Home and was responsible for Hackney and City community health services.

The trust served a diverse population: the London Borough of Hackney and the City of London. In 2010, the Indices of Deprivation showed that Hackney was the second most deprived local authority in the country, although there was evidence of less deprivation period 2007 to 2010. In contrast, the City of London (which is the country's smallest county and holds city status in its own right) was judged as being the 262nd most deprived local authority (there were 326 local authorities with the first being the most deprived). Both Hackney and the City of London had increasing populations and higher than average numbers of patients from Black, Asian and minority ethnic communities. There was a consensus view from local stakeholders, patients and staff that The Homerton was part of the local community and met the needs of its local population well.

The trust provided specialist care in obstetrics and neonatology, foetal medicine, fertility, HIV, keyhole surgery, asthma and allergies, bariatric surgery and neuro-rehabilitation across east London and beyond. The trust had seen some changes in leadership in 2013 with three out of five executive directors having been appointed in 2013. However, only one of these three executive directors, the Chief Nurse and Director of Governance, joined the trust from an external organisation. The Chief Executive and the Chief Operating Officer were internal appointments and were working in other senior roles within the trust prior to taking up their new posts in 2013.

### Staffing

The trust had over 500 beds and employed over 3,500 staff. A further 1,000 staff were either contracted to work or placed for training in the Homerton. Many of the senior staff at the trust had been working at the hospital for a number of years and students we spoke with said they were keen to come back to work at the trust when they qualified. However, in the medical wards we found there were nursing staff shortages, and that these were having an impact on patient care in being able to provide care in a timely manner. The trust spent 9.9% of total staffing costs on agency staff, nearly double the spend across London. Staff sickness rates overall at the trust were just below London and England averages, midwifery staffing sickness levels, were significantly lower and were 2% compared with an England average of 4.3%.

### Cleanliness and infection control

All areas visited at the Homerton were clean and levels of cleanliness were the same on our unannounced inspection visits. In the NHS staff survey of 2012, 47% of staff said that hand washing facilities were always available which was worse than expected. However, when we visited, we saw there were adequate hand washing facilities and staff and visitors had access to liquid soap hand cleansing gel. During the 12 months from August 2012 to July 2013, the trust reported four cases of meticillin-resistant staphylococcus aureus (MRSA) infection; this was within a statistically acceptable range relative to the trust's size and the national level of infection. During the same time period, there were 10 reported cases of Clostridium difficile, which was also within a statistically acceptable range given the size of the trust.

We rated the Homerton as a good hospital with an outstanding accident and emergency (A&E) department. Staff felt valued and enjoyed working in the hospital, and patients felt cared for and had faith in the staff looking after them.

# Summary of findings

## The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

### Are services safe?

The Homerton was a safe hospital in which to receive treatment. We identified areas where staffing levels should be increased and this will improve safety for patients.

The rates of new pressure ulcers developing at the Homerton were lower than the average rate in English hospitals. The trust had two Never Events (events so serious they should never happen) between 1 December 2012 and 31 November 2013 – this figure was no more or less than trusts of a comparable size. We found that staff had learnt from the events to minimise the risk of them occurring again. All staff were aware of these events and could describe the processes that had been put in place to prevent them happening again.

The hospital was clean and well maintained. The roof required some repair work. However, the issues with the roof did not concern the clinical areas.

Good



### Are services effective?

Patient care was effective. The staff worked well collaboratively to ensure patients got the best possible outcomes. National, evidence-based guidelines were followed and monitored; departments audited their work and shared their findings in departmental meetings. Before our inspection, we had some concerns about re-admission rates for patients who had been discharged from the Homerton – specifically, that patients may be being discharged earlier than appropriate. However, we found this was not the case and patients were overall discharged in a timely manner.

Overall, the multidisciplinary teams (MDTs) worked well together and this was particularly the case in the A&E department.

Good



### Are services caring?

Most patients we spoke with told us that staff were caring and respectful, and we saw staff treating patients with dignity and respect. During busy times in outpatients and A&E volunteers and staff gave patients food and drink while they waited to see a doctor. The one exception where this was not the case was in the maternity services; there were some negative comments about the attitudes of a few midwives at night from women on the maternity wards.

Good



### Are services responsive to people's needs?

Services at the Homerton were responsive to patients' needs. The trust was meeting A&E targets for 95% of patients being seen within

Good



# Summary of findings

four hours of arriving at the hospital. Although we initially had concerns that the number of unplanned re-admissions was higher than expected, the trust was able to explain why the figures were high.

Patients told us that staff attended to their needs promptly.

## Are services well-led?

The hospital was well led. Staff told us they felt supported and valued. The chief executive, medical director and chief nurse were well known at all levels of staffing; staff felt confident that not only would they be able to identify executive team members if they came onto the wards but that in many cases the executive team members would know them too. The non-executive board members we met were not as well known by the staff. We met with the council of governors and non-executive directors who clearly understood their role and were highly supportive of the leadership of the trust board.

A clear strategy for what the trust was achieving and aimed to achieve was evident and staff demonstrated the values of the trust – personal, safe, respectful, responsibility.

Good



# Summary of findings

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

### Accident and emergency

Since April 2013, the accident and emergency (A&E) department had consistently been meeting the government's 95% target for admitting, transferring or discharging patients within four hours of their arrival in A&E. Initiatives were in place to respond to patient need and to ensure patients were seen in a timely manner.

Approximately a third of patients attending the department received services from the primary urgent care centre (PUCC). The role of a non-clinical navigator (NCN) was introduced to further support this patient group. The NCN supported patients to locate and register with their local GP practice. This meant patients were able to have their primary medical needs met in the local community rather than coming to the A&E department.

The team were aware they had a high number of patients regularly re-attending the department. The first response duty team (FRDT) was established to address this. The FRDT worked with patients to identify their support needs and meet those needs in the community, reducing the number of patients requiring hospital admission.

We observed positive interactions between staff and patients. Staff took the time to listen to patients and explain to them what was wrong and any treatment needed. Patients told us they had all their questions answered and felt involved in making decisions about their care.

The staff we spoke with were proud to work for the A&E department and felt there was a 'can do' attitude within the team. There were processes in place to monitor the quality of the service and respond to areas highlighted as requiring improvement. We saw that learning was shared among the staff team regarding Never Events, incidents and complaints within the department and across the hospital. Staff were encouraged and enabled to attend training courses and further their skills and knowledge to improve the service provided to patients.

Outstanding



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

The medical care wards we visited assessed and reviewed patients' nursing and medical needs adequately and we found care was delivered in accordance with patients' needs. However, some documentation, such as wound care management records, were not always adequately completed and there was a reliance on verbal

Good



# Summary of findings

nursing handover in place of appropriate recording of care planning and delivery. Some systems in place, including falls assessments and identifying deteriorating patients, did not meet nationally recognised guidelines.

The level of medical staff cover was good, as were the systems in place to ensure patients received multidisciplinary care. We found there were effective ward handover processes, but on some wards there were at times insufficient levels of trained nursing staff, which meant that patients did not always receive the care they needed in a timely fashion. There was a reliance on bank and agency staff to cover shifts, which was at times to the detriment of patients, including those who needed prompt pain relief and those with dementia.

Patients received compassionate care from well- trained staff who promoted their privacy and dignity. The majority of patients we spoke with were happy with the care they received, although some patients told us they had not been fully involved in their care, or informed about their progress. We found consultants did not always involve patients or their families in 'do not attempt resuscitation' (DNAR CPR) decisions.

The trust had appropriate arrangements in place to monitor the quality of the service, and we found that improvements had been made when there had been incidents or complaints relating to the medical wards. Staff were not always aware of the performance of their ward because they were not familiar with the performance dashboard which had been implemented shortly before our inspection.

## Surgery

Patients we spoke with during our inspection were positive about the care and treatment they had received. They were complimentary about the staff in the service and felt informed and involved. One patient told us they had chosen to be treated at the Homerton and another patient described it as "fantastic". The two surgical wards had performed poorly in the Friends and Family test, but action had been taken to improve this. For example, staffing levels had been increased. Patients knew how to raise a concern and complaints were managed in line with the trust's policy and procedure.

There were mechanisms to ensure that patients were kept safe. Patients were assessed before their surgery to ensure this was appropriately managed. They were also assessed when admitted to a ward area to determine the level of nursing required. We found some inconsistency and gaps in nursing documentation, such as repositioning charts, and patients' preferences had not always been documented.

Good



# Summary of findings

Patients received effective care that met their needs. Nationally recognised guidelines and pathways were followed and we found evidence of good multidisciplinary working. Theatres were responsive and had appropriate staffing coverage overnight and at weekends.

Staff were proud to work for the service and they had confidence in both service and trust leadership. There was an open, supportive culture where staff were encouraged to report concerns and were involved and empowered to make changes. There were clear clinical governance arrangements in place and managers were aware of the risks in their area and what action was being taken to reduce them

## Intensive/critical care

Patients' needs were being met by the service, and patients were cared for in a supportive way. There were criteria for admission to the unit run by the intensive care staff and the critical care outreach team. Patients received safe care and were treated according to national guidelines and evidence-based practices. Patients and their families told us they felt the unit was safe and the care they received was "excellent".

Staff used clinical governance methodologies such as audits to monitor the quality and outcomes of their patients. They reported incidents so they could improve on the quality of care patients received. There were processes to ensure patients received care and treatment that was as risk free as possible, and other processes to prevent the spread of infection and monitor risk.

Good



## Maternity and family planning

We spoke with 30 women, 25 midwives, eight managers, five doctors, two domestic staff, a house keeper, a porter and reception staff. We received two comment cards. We found that the maternity and family planning services were safe. Whenever possible, women were protected from avoidable harm. There were effective systems in place to ensure the care delivered met patients' individual needs. Staff had appropriate training and followed standard operating procedures as well as relevant guidance to deliver care.

Staff were caring and described as "approachable" and "attentive". However, there were some negative comments about the attitudes of a few midwives at night from women on the maternity wards.

The trust served a diverse population and was responsive to patients' needs by initiating several initiatives such as bilingual maternity support workers and the "husband/partner staying overnight pilot".

Good



# Summary of findings

Staff were aware of the trust's values and vision and felt supported by senior management to report incidents without the fear of being blamed. Several midwives told us they had chosen to work at the Homerton because of the support and professional development they received, even though it was not their local hospital

## Services for children & young people

We spoke with 12 children, 15 parents, nine nurses, three managers, four doctors and received 11 comment cards. We found that children's services were safe. Whenever possible, children were protected from avoidable harm.

There were effective systems in place to ensure the care delivered met children's individual needs. Staff had appropriate training and followed standard operating procedures as well as relevant guidance to deliver care. Staff were caring and described as "loving", "easy to talk to", "very supportive, through a difficult time" and "willing to go the extra mile".

The trust served a diverse population, was responsive to children's needs, including services such as City and Hackney Young People's Services Plus (CHYSPPlus), which provides holistic health services for young people aged 11-19 years. Staff were aware of the trust's values and vision, and felt supported by senior management. They told us they could report incidents without the fear of being blamed.

Good



## End of life care

Patients received safe end of life care. There were systems in place to ensure patients were kept safe. They were given information and support to make decisions about their care as inpatients, and they were involved in the planning of their discharges. Patients' individual care needs were being met within the hospital and effective discharge planning took place that used established links with local community services including St. Joseph's Hospice in Hackney. Staff received appropriate training and support, and understood the good practice guidelines and pathways in place. The service was well led by an experienced palliative care team that was respected and valued by medical, nursing and other colleagues in the hospital.

Good



## Outpatients

The outpatients department was a busy department and provided safe care. The department was clean and well maintained. When clinics were running late, patients were told how long the delays would be and given the reason for them. There were sufficient numbers of staff on duty.

Good



# Summary of findings

The outpatients department generally met the Department of Health guidelines for ensuring patients received appointments within 18 weeks of referral. Patients told us staff were caring and explained their treatment to them. There were clear lines of leadership in the department and staff knew to whom to escalate concerns.

# Summary of findings

## What people who use the hospital say

Before our inspection, we had looked at the last inpatient survey and the Friends and Family test. In both, the trust had scored lower than the average for England. In the adult inpatient survey of 2012, the trust been identified as a higher than average risk because of responses to the following question, 'Did you have confidence and trust in the nurse treating you?' The trust also had an elevated risk following responses to the following question, 'Do you think the hospital staff did everything they could to help control your pain?'

In the recently introduced Friends and Family test, the trust performed lower than the average for England

although the response rate was also below average. The trust also came in the bottom 20% nationally for 23 out of 69 questions in the Cancer Patient Experience Survey and the National Bereavement Survey of 2011; the North East London (NEL) primary care trust (PCT) cluster (where the Homerton was based) scored in the bottom 20% for 8 indicators.

However, the NHS Choices website showed the trust overall had a score of 3.5 out of a possible 5 stars, and that comments were largely positive. This was also the case when we spoke with patients and their friends and family during our inspection.

## Areas for improvement

### Action the hospital MUST take to improve

The trust must take appropriate steps to ensure that at all times there are sufficient members of suitably qualified, skilled and experienced staff employed on the medical wards.

The trust must ensure that patients are protected against the risks of unsafe or inappropriate care and treatment by means of accurate record keeping, which should include appropriate information and documents in relation to the care and treatment planned and provided to each patient.

The trust must ensure patients and/or their relatives are involved in 'do not attempt cardiopulmonary resuscitation' (DNAR CPR) decisions and ensure these are adequately documented.

### Action the hospital SHOULD take to improve

- The trust should ensure an evidenced-based early warning system is used. The national early warning score (EWS) was not in use at the trust and therefore the systems the trust used were not as robust as is nationally recommended.

- The trust should consider introducing a dementia identifier: for example, the 'forget-me-not' and 'This is me' style patient information templates, because these are considered to be best practice by the Alzheimer's Society.
- The trust should consider ensuring local and general anaesthetic drugs are stored separately from each other to minimise the risk of error.
- The trust should ensure intravenous fluids are kept locked and are not were accessible to patients by providing adequate storage in A&E
- The trust should ensure there is adequate space in the theatre reception area to ensure the privacy and dignity of patients is always maintained.
- The trust should consider introducing 'patient's safety at a glance' boards across all wards to improve communication and safety.
- The trust should consider introducing staff picture boards on each ward so patients and visitors know whom to approach with any concerns or issues.
- The trust should consider reinstating the out-of-hours patient visiting service from the palliative care team.

## Good practice

The first response duty team (FRDT) provided multidisciplinary input to co-ordinate the discharge

arrangements for patients presenting at the A&E department. The trust and the London Borough of

# Summary of findings

Hackney jointly funded the FRDT that provided a service seven days a week. Eighty-seven per cent of the referrals made to the FRDT enabled the patient to go home straight from A&E without needing admission to a ward.

A 'spider checklist' was produced to help the trust proactively monitor that they were meeting the national clinical quality indicators for the A&E department and prevent duplication of work between A&E and speciality teams. This enabled care to be delivered more promptly and lead to effective care for patients. The 'spider checklist' ensured effective communication and documentation regarding a patient's needs. It included information about the patient's diagnosis, investigations undertaken, and a recommended time interval for medical review. This helped the ACU prioritise patients and highlight any outstanding investigations the patient required.

The elderly care unit (ECU) had three dementia care assistant posts to support patients with dementia with one-to-one stimulation. The trust should ensure that these posts remain, in addition to the nurse and nurse assistant staffing establishment, to continue to enhance the experience of patients with dementia.

The palliative care nursing team and the bereavement team provided a supportive service that was that was well known to medical, nursing and therapy staff. Staff working on the medical wards told us how their own knowledge and practice regarding palliative and end of life care had been improved by the confidence and competence brought by individuals within these teams.

The pharmacy department was involved in joint working with London Ambulance Service and the Hackney Clinical Commissioning Groups to introduce 'green bags' so that patients' own drugs could be brought into hospital safely and transferred safely between different healthcare settings.

Pregnant women who meet the criteria could have their labour induced in outpatients, known as outpatient induction of labour. It reduces the amount of time women will need to stay in hospital before their labour begins, allows women to stay at home and wait for labour to start and makes the process of induction more normal.

Access to maternity services was also provided through a maternity telephone helpline that was available from 10am till 6pm, seven days a week. The helpline advised women who were booked or wanted to book at the trust for their pregnancy. We found that it was staffed by experienced midwives who had specific training about domestic violence, confidentiality, and handling difficult and emotional calls. The helpline was commended by a stakeholder whose role was to represent the experiences of women using the trust's maternity services.

The outpatients service used technology to ensure patients' relatives and carers could be involved in their care. A clinic appointment had been organised so that a close relative could join the consultation from another country via Skype.

# Homerton University Hospital

## Detailed findings

### Services we looked at:

Accident and emergency; Medical care (including older people's care); Surgery; Intensive/critical care; Maternity and family planning; Children's care; End of life care; Outpatients

## Our inspection team

### Our inspection team was led by:

**Chair:** Dr Mike Lambert, Consultant, Norfolk and Norwich

**Team leader:** Michele Golden, Care Quality Commission (CQC)

The team included CQC inspectors and a variety of specialists: student and qualified nurses, consultant and junior physicians, consultant and junior surgeons, medical director, midwives, trust chief executive, expert patient representatives.

## Background to Homerton University Hospital

The trust had been inspected seven times since registration with CQC. The most recent inspection of the Homerton itself was in April 2013 when the trust was found to be compliant with all regulations relating to the services inspected. This was the fourth inspection since May 2011. Mary Seacole Nursing Home had been inspected three times since November 2011 with the last inspection being carried out in October 2013 – again all outcomes inspected were found to be compliant. An inspection of the trust's

community services was carried out in December 2013 and January 2014 and, although the report has not yet been published, the trust was found to be compliant in all outcomes inspected.

## Why we carried out this inspection

We inspected this hospital as part of our in-depth hospital inspection programme. We chose this hospital because it represented the variation in hospital care according to our new intelligent monitoring model. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations. Using this model, Homerton University Hospital (the Homerton) was considered to be a high risk service.

## How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to patients' needs?

# Detailed findings

- Is it well-led?

The inspection team always inspects the following core services at each inspection:

- Accident and emergency
- Medical care (including older patients' care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Services for children and young patients
- End of life care
- Outpatients.

Before visiting, we reviewed a range of information we hold about the hospital and asked other organisations to share what they knew about the hospital. We carried out an announced visit on 6 and 7 February 2014 and we carried out unannounced visits in the evenings of 13 and 15 February 2014.

During the visit we held focus groups with a range of staff in the hospital, including nurses, midwives, doctors, physiotherapists, occupational therapists, porters, domestic staff and pharmacists. We interviewed executive and non-executive board members and we met with the council of governors. We talked with patients and staff from all areas of the hospital including the wards, theatre, outpatients and the A&E departments. We observed how patients were being cared for, and talked with carers and/or family members and reviewed patient care or treatment records of patients. We held a listening event on 5 February 2014 at the Tomlinson Centre where patients and members of the public shared their views and experiences of the location.

# Accident and emergency

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

## Information about the service

The accident and emergency department (A&E) provided a 24-hour service, seven days a week. The department had facilities for assessment, treatment of minor and major injuries, resuscitation, and children’s A&E known as children’s emergency assessment unit(CEA). The department included a primary urgent care centre (PUCC) and an observational medical unit (OMU). The OMU was used to support patients who were unable to be discharged directly from the A&E department but were not likely to require inpatient admission for longer than 24 hours.

Our inspection included two days in the A&E department as part of an announced inspection and an unannounced follow-up to the department on a Saturday night. During our inspection, we spoke with the clinical and nursing leads for the department. We spoke with four members of the medical team (at various levels of seniority), 15 members of the nursing team (at various levels of seniority), two of the non-clinical navigators (NCNs) who support patients to register and book an appointment with their local GP practice, four members of the reception staff, a member of the first response duty team (FRDT), the lead for clinical governance for the department and the psychiatric liaison team. We also spoke with 11 patients, observed the ward round of the OMU and the evening medical handover, and undertook general observations within all areas of the department, PUCC and the waiting room. We reviewed the medication administration and patient records for patients in the OMU.

The CEA unit within the accident and emergency (A&E) department saw an average of 12,000 children a year. On

average the A&E department saw over 100,000 patients a year, which equated to just over 2,000 patients a week. During the four-week period from 30 December 2013 to 26 January 2014, the department saw 8,582 patients. Within those four weeks, 97.1% of patients were seen and either transferred, admitted or discharged within the four-hour target. The number of patients admitted to a ward was 1,226. This equated to an admission rate of 14.3%.



# Accident and emergency

## Summary of findings

Since April 2013, the department had consistently been meeting the government's 95% target for admitting, transferring or discharging patients within four hours of their arrival in A&E. Initiatives were in place to respond to patient need and to ensure patients were seen in a timely manner.

Approximately a third of patients attending the department received services from the primary urgent care centre (PUCC). The role of a non-clinical navigator (NCN) was introduced to further support this patient group. The NCN supported patients to locate and register with their local GP practice. This meant that patients were able to have their primary medical needs met in the local community rather than coming to the A&E department.

The team was aware that they had a high number of patients regularly re-attending the department. The first response duty team (FRDT) was extended to address this. The FRDT worked with patients to identify their support needs and meet those needs in the community, reducing the number of patients needing hospital admission.

Staff took the time to listen to patients and explain to them what was wrong and any treatment required. Patients told us they had all their questions answered and felt involved in making decisions about their care.

The staff we spoke with were proud to work for the A&E department and felt there was a 'can do' attitude within the team.

## Are accident and emergency services safe?

Good



There were systems to protect patients and maintain their safety. There were adequate staffing levels to provide safe care to patients. Staff were aware of the challenges within the department regarding identification and protection of specific patient groups and were working towards addressing those challenges.

### Learning and improvement

All incidents were reported through a centralised system. Senior nurses and consultants reviewed the incidents reported and analysed the data to identify any trends. Learning from incidents was disseminated to the staff team.

We were given examples of when incidents had led to increased learning and changes of procedure. One example was a patient who been sent for an x-ray and had received an X-ray of the wrong area of their body because they didn't have an identification band. A reminder was sent to all staff to double check patients' identification before tests were undertaken or treatment given. The other hospital departments were instructed to complete an incident form if they received a patient from A&E without an identification band. During a ward round on the OMU, staff identified that one patient did not have an identification band on their wrist and another patient had the incorrect spelling of their name on their band. The staff corrected these errors as soon as they were identified. We undertook an audit during our inspections and saw that all patients had the required identification band.

Data held about the trust showed it was performing worse than expected in regards to medication errors per 1,000 patients. We were informed of an incident regarding a medication error within A&E and how it had led to changes in practice. When patients were in the majors area of the department their medication was recorded on a 'cascard'. On transfer to the OMU, their medication was recorded on a medication administration record (MAR). Medication was given twice to one patient because staff had looked at the 'cascard' rather than the MAR for a patient in the OMU. Since this incident, it was made clear



## Accident and emergency

on the 'cascards' that staff were to refer to the MAR. We were informed during our inspection that one patient had missed one dose of an antibiotic and staff informed us that this had led to a delayed discharge for that patient. We reviewed the MAR charts for both patients on the unit during our unannounced inspection and found that medication had been administered and recorded appropriately.

A Never Event occurred in the trust in a unit outside the A&E related to the improper insertion of a nasogastric tube. During our inspection, one patient presenting at A&E needed a nasogastric tube inserted. We observed staff booking the patient for an x-ray to ensure the tube was correctly inserted before continuing with treatment in line with the learning from the Never Event.

### Staffing, systems, processes and practices

The staffing establishment for the A&E and CEA department was reviewed regularly to ensure there were appropriate staffing levels to support patients safely. Staffing numbers were based on activity level and trends previously identified. For example, additional staff were included in shifts during the winter and twilight hours because the department saw more patients during that time. The observational medical unit (OMU) had seen an increase in activity and an additional health support worker was employed to work in the mornings to help patients with their patient care.

The staff told us there was flexibility within the staffing budget to increase staffing levels and that they had autonomy to make these decisions. The senior nurse on a shift was authorised to make the decision to increase the staffing levels if they felt it was required to adequately support the patients within the department. Staff were given flexibility in reallocating staff within the department according to patient need. For example, we observed during the medical handover that a decision was made to close the minor injuries unit because it was not being used, and to transfer staff across to support another area of the department that was seeing a higher volume of patients.

There were systems in place to maintain the safety of patients; however, for some patient groups these required improvement. There were processes in place to support older patients who had fallen or were at risk of falling. The discharge process required staff to highlight if a patient was over 65 years and had either come to A&E

because of a fall or was at risk of falling. This process provided an automatic referral to the trust's falls specialist nurse who assessed the patient to establish if they needed additional support at home and a referral to the falls clinic. The process also provided an automatic referral to the FRDT team who reviewed whether additional measures may be required at home or the community. There were also processes in place to maintain the safety of older patients by ensuring they were not discharged home during the night.

The trust highlighted that a continuing challenge for the A&E department was the identification of acute oncology patients. The NHS National Cancer Peer Review Programme highlighted that the patient flagging system was not able to identify and highlight acute oncology patients presenting with sepsis. This meant that decisions regarding treatment and care could not be made without access to the most recent clinical information. The team relied on patients telling them if they were receiving active treatment for cancer. However, this was difficult for patients who could not speak English or were too unwell to inform the staff. There was no system in place for staff to identify patients with cancer other than by speaking to them. The staff team was being trained on how to identify signs of sepsis so this could be treated promptly, and the department had introduced the 'Sepsis Six' interventions to treat patients. Sepsis Six was the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis. The discharge process required staff to identify if a patient had cancer, and, to maintain continuity of care, information was transferred to their treating clinician to inform them the patient had been seen in A&E.

Our intelligent monitoring information identified that the trust was at risk regarding the proportion of patients receiving a risk assessment for venous thromboembolism (VTE). The admission paperwork for the OMU prompted staff to risk assess for VTE. The care records we reviewed showed that all patients had been risk assessed for VTE and interventions had been put in place to manage any identified risk.

There were systems to protect patients from the risk of hospital acquired infections. We observed the domestic supervisor inspecting the cleanliness of the floors. They discovered that one of the floors within the department was wet and the domestic staff dealt with this



# Accident and emergency

immediately. We saw that, when cleaning was required within the department, this was identified and addressed promptly. There were hand hygiene facilities available throughout the department and we observed staff washing their hands in between patients. An isolation room was available in A&E to treat patients presenting with an infection, in order to minimise the risk and spread of infection to other patients.

Medication was not always stored safely. Intravenous fluids were kept unlocked and were accessible to patients. Staff were aware that the fluids should be locked away and said that a lack of storage space was the reason why they were not. All other medication was stored in a locked cabinet and was not accessible to patients.

## Safeguarding

All safeguarding concerns were raised through a centralised reporting process. A senior member of staff reviewed the concerns raised to ensure a referral had been made to the local authorities' safeguarding team. Staff received safeguarding children and safeguarding vulnerable adults training. The staff we spoke with were aware of how to recognise signs of abuse and the reporting procedures. They were given feedback on concerns they raised and the outcomes of investigations.

Training was given to staff on how to identify and support victims of domestic violence. Staff were told there was a requirement to speak to patients on their own if they had concerns that they may have been victims of domestic violence. A database was held on patients who had been such victims, in order to help the team identify re-attenders. Information was given to staff about how to support victims to report the domestic violence to the police and local authority.

The department collected data on patients who had been a victim of an assault. This information was shared with partners in the community and other London hospitals to protect patients and to help inform the police about the numbers of violent crime in the area.

An alert was put on a patient's records if they were known to be violent or to exhibit aggressive behaviour. This meant staff were able to identify when they required additional support to protect themselves and other

patients in the department. If a patient was known to be aggressive, security staff were available and staff were not expected to treat the patient or go into the patient's bay on their own.

## Anticipation and planning

Staff received major incident training to prepare them on how to deal with major incidents within the city and the impact they would have on the trust's A&E department. For example, staff were told what to do if someone presented at A&E contaminated with chemicals, or if there was a major incident such as a bomb explosion in the city. The training included information about how to treat patients, changes to processes to reorganise the A&E department and increase capacity, and changes to discharge arrangements to ensure patients' safety after leaving the department.

## Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate



## Performance, monitoring and improvement of outcomes

Trusts in England were tasked by the government with admitting, transferring or discharging 95% of patients within four hours of their arrival in the A&E department. Homerton University Hospital NHS Foundation Trust was consistently meeting this target. The trust dropped to its lowest (92.1%) in April 2013. Since then the trust had consistently been above the 95% target. During the four-week period before our inspection (from 30 December 2013 to 26 January 2014), the department saw 8,582 patients and 97.1% of these were seen and either transferred, admitted or discharged within the four-hour target.

The assessment nurse in A&E 'triaged' patients to ensure they were directed to the appropriate service within A&E. The assessment nurse undertook patient observations and arranged for blood tests to be taken when required so the results were available when the patient was seen by staff in minor injuries or majors. This ensured the patient did not waste undue time waiting for results to be returned. A 'meet and greet' nurse was also available to



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review patients' needs in the waiting room and to identify any immediate needs: for example, pain relief while the patient was waiting to be seen. All patients were seen in time order unless the assessment or the 'meet and greet' nurse identified that their needs required them to be prioritised.

## Using evidence-based guidance

Trust policies, procedures and guidelines were based on the nationally recognised best practice guidance: for example, the National Institute for Health and Care Excellence (NICE) guidelines. Exception reports were submitted to the trust to develop policies and guidelines not in line with recommendations by NICE, and these included justification as to why the NICE recommendations were not being followed.

All information regarding pathways, protocols and procedures within the A&E department were available on the intranet for staff to access. This included information on best practice guidelines and NICE guidelines. The 'Up to date' resource was available on the intranet for staff to refer to; this provided a database of all new and current best practice.

## Staff, equipment and facilities

The department had representation from a number of senior staff (both medical and nursing) to provide the seniority and experience required to provide an effective service. The trust's policy was not to have a locum leading the night shift in order to ensure there were senior staff available who were more familiar with the department's policies and procedures and could therefore provide a more effective service during its busiest times.

Staff had access to the equipment and facilities needed to provide an effective service. Diagnostic and screening equipment was available and in most cases accessible in a timely manner for patients in A&E. X-rays and CT scans were available 24 hours a day, seven days a week. The department had the equipment to undertake blood tests (for example, full blood counts) at the point of care. A patient we spoke with told us their x-ray was available "instantly". They said, "The staff had looked at the x-ray before I even got back." There were monitors on the outside of the cubicles in majors so that staff could monitor patients' health.

Specialist advice was available within the department to assess patients' needs and there were arrangements in place for critical care transfers for patients who needed emergency surgery that could not be performed out of hours at the trust.

## Are accident and emergency services caring?

Outstanding



A&E staff were caring and treated patients with dignity and respect. One patient told us they were given a choice by the ambulance service as to which A&E department they wished to attend and they chose this hospital because "they are the best". Staff were responsive to patients' needs and treated them as individuals. One patient told us the care they received was "excellent" and they "couldn't fault them [the staff]".

## Privacy and dignity

Privacy curtains were available in all bays and were drawn while the patients were being assessed or receiving treatment. The environment in the majors area had been adjusted to reduce the gap between the privacy curtain and the wall to ensure patients' privacy was maintained.

The isolation room was used in majors for any gynaecological patients needing examination; this was to ensure the privacy of the patient because the door to the room could be locked to stop patients accidentally walking in.

Staff checked with patients to establish if they were happy for friends and family to be present during an assessment and examination, and they did not discuss their diagnosis or treatment in front of carers if the patient did not wish them too. We observed staff knocking or announcing their presence before entering a bay.

## Involvement in care and decision making

Patients told us they felt informed about their patient journey and that staff were responsive to their needs. They told us, "Everyone made sure we knew where we were going." They told us staff dealt with their needs quickly and were polite when speaking to them. We



## Accident and emergency

observed staff explaining to patients if there was going to be a delay in seeing a doctor, what the reason for that delay was and how long they would have to wait to be seen.

Staff were responsive to patients' needs, checking whether they were in pain and offering pain relief when appropriate. They explained why certain pain relief was not available because of previous medication taken, but whenever possible gave patients a choice as to what type of pain relief was available. They also explained what the different medication would do, so patients were able to make an informed decision about the medication they wished to take.

Doctors explained to the patient what their initial diagnosis was and explained the process for confirming that and any further diagnostic tests required. During a ward round of the observational medical unit (OMU), we observed the consultant taking their time and explaining to the patient what course of treatment was suitable. Patients told us they were always kept up to date with information about their health and the tests and treatment required. Staff explained the results of diagnostic and screening tests and what this meant for the patient's health. It was explained to patients why they were required to stay in the OMU overnight. Patients were informed of when they were to be discharged and provided with information about follow-up appointments.

We observed in one area of the department that aftercare arrangements were discussed with the patient and staff ensured arrangements were made to contact friends or family members if additional support was required on discharge and then at home: for example, if the patient had been sedated.

Staff checked that patients did not have any further questions before they left the department.

Staff were respectful of patients' cultures and religious beliefs. For example a kosher vending machine was available in reception providing food and drink for Jewish patients.

We spoke with a support worker who was attending the A&E department with the patient they supported, who

had learning disabilities. They told us staff spoke directly to the patient as well as the support worker to ensure both patients knew what the process was and the outcome of their investigations.

When treating children, the staff would explain to the child in appropriate language what was wrong what treatment they needed. This was done in a way the child understood and a further detailed explanation was given to their parents with information about follow-up appointments and aftercare arrangements.

### Patient feedback

Since April 2013, patients have been asked whether they would recommend hospital departments to their friends and family if they required similar care or treatment. The results of these have been used to formulate NHS Friends and Family tests. Between August 2013 and November 2013, 93% of patients asked were either 'likely' or 'extremely likely' to recommend the trust's A&E department to friends and family. This was higher than the average for England. The staff team regularly reviewed and discussed feedback from patients in staff meetings. One theme received from patient feedback was that patients perceived they waited too long to receive support from the primary urgent care centre (PUCC). While the four-hour target was not being breached, staff wished to address this concern to improve patient experience. The team introduced non-clinical navigators (NCNs) and 'queue busters' to ensure patients were informed about the wait and the service, and to identify if they were able to have their needs met more quickly by accessing a different service.

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

Outstanding



The A&E department had introduced a number of initiatives to improve their responsiveness to the needs of the local population. The team learned from complaints received and reviewed ways to improve both their practice and patient experience within the department.



# Accident and emergency

## Access to services

The local population was very diverse and patients spoke a number of different languages. This diversity was reflected in the staff team and a wide number of languages were spoken by staff. This skill set within the staff team was used to effectively communicate with patients. Staff also used 'language line', a translation service, in order to communicate with their patients. At the time of our inspection, there was a lack of written information available in languages other than English because of some inaccuracies in translation. New information was being developed but was not yet available for patients to access. Because of the lack of written information available in other languages, a post-discharge telephone call was made to patients. This gave them follow-up information and reviewed their aftercare arrangements to ensure they received everything they needed to manage their health needs.

Within the A&E department, a position of a non-clinical navigator (NCN) was established to support patients accessing the primary urgent care centre who were not registered at a local GP practice. The role of the NCN was to support patients to register and book an appointment with their local GP practice. The NCN provided patients with information about their local GP practice, told them how to register with the practice, and supported them in booking their first appointment. This helped patients to access a GP for their primary health care needs that did not require attendance at the A&E department. It also helped to educate patients who were unsure what the role of a GP practice was.

The department's performance against the four-hour target was reviewed daily. An investigation was undertaken for all cases that breached this target to establish why the target had not been met and to identify what improvements needed to be made to reduce the chance of the breach occurring again. It was previously identified that some of the delays were due to the reduced availability of porters within the hospital. The trust had since employed more porters to reduce this delay.

The centralised recording system alerted staff to all patients waiting three hours or more to remind staff to meet that patient's needs in a timely manner. A site report was circulated throughout the trust every three hours to inform staff of the waiting times patients were

experiencing in A&E. Staff within A&E identified patients needing admission to a ward as early as possible in order to give the wards time to organise a bed and create capacity within their team to facilitate the admission. Staff told us that the whole hospital worked together to ensure patients were transferred and admitted in a timely manner. The acute care unit (ACU) admitted all patients regardless of speciality (excluding gynaecology). A 'spider checklist' was produced to help the trust meet the national clinical quality indicators for the A&E department and prevent duplication of work between A&E and speciality teams. This enabled care to be delivered more promptly and lead to effective care for patients. The 'spider checklist' ensured effective communication and documentation regarding a patient's needs. It included information about the patient's diagnosis, investigations undertaken, and a recommended time interval for medical review. This helped the ACU prioritise patients and highlight any outstanding investigations the patient required.

Patients commented that they were "very happy" with the service and the speed with which they were seen and treated.

## Links with community services

There was a system to identify patients who required district nursing support. Once identified, action was taken within 24 hours to ensure the local district nurse was located and a package of care was put in place to support the patient in the community and reduce the need for admission to a ward.

Community matrons came to the department to review any patients accessing A&E that they supported in the community; this gave them the opportunity to identify if the patients had any additional needs.

## Leaving hospital

Data held showed the trust was tending towards worse than expected for the percentage of unplanned re-attendance at A&E. In response to the number of unplanned re-attendances the first response duty team (FRDT) had been established in 2012 to provide multidisciplinary input to co-ordinate the discharge arrangements for patients presenting at the A&E department. However, between January 2013 and December 2013, the average 7-day re-attendances for the A&E department was 918 patients, which equates to 9.6%. In response to this, the trust had increased the size



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of the team. Patients who had attended A&E five times or more within a month were referred to the FRDT to review their health and social care needs. Direct referrals were also made to the FRDT for patients identified as needing more support within the community in order to be discharged home: for example, if they required equipment to be fitted in their home so that they could access it more easily. One patient had attended A&E 14 times in one month and 18 times the month after. This patient had specific needs regarding housing and the FRDT were able to locate permanent housing for them. Since the input from the FRDT, the patient had not attended A&E. The trust and the London Borough of Hackney jointly funded the FRDT that provided a service seven days a week. Eighty-seven per cent of the referrals made to the FRDT enabled the patient to go home straight from A&E without needing admission to a ward.

The FRDT identified that, during September 2013, 35 patients had attended A&E more than five times in one month, and in October 2013 it was 26 patients. It was identified that 24 of the 35 patients who had presented in September were attending the urgent care centre to get their dressings changed, and in October 2013 16 patients had re-attended to get their dressings changed. The local Clinical Commissioning Group (CCG) identified in their clinical quality review that not all community or practice nurses were able to deal with dressings effectively. A planned care approach was being developed to avoid patients returning to the A&E department or to the PUCG to get their dressings changed.

### Vulnerable patients and capacity

The psychiatric liaison service from a neighbouring trust was based within the A&E department to support patients with mental health needs. The assessment nurse identified whether a patient was presenting with mental health needs and communicated this to the liaison service, so they were able to provide additional support to manage the patient's mental health needs while the A&E staff managed their physical health needs. The liaison service was also informed if a patient attending the department via ambulance had had mental health needs identified. The psychiatric liaison service was part of the home treatment team within the trust and was therefore able to promptly locate whether the patient was known to the service and, if so, to identify their care co-ordinator. This allowed the team to identify the care package in place to support this patient, help them

manage their mental health needs in the community and reduce the need for an inpatient admission. If a patient was from out of area, the liaison service spoke to the relevant mental health team to provide the patient with the required support. If the patient was not known to the service, the liaison service undertook a mental health assessment and initiated a package of care for them through the home treatment team. The psychiatric liaison service provided training to the staff team in A&E on how to identify mental health symptoms and how to support patients with mental health needs.

Staff were knowledgeable about how to support patients who lacked capacity. They were aware of the need to assess whether a patient had a temporary or permanent loss of capacity and how to support patients in each situation. If there were concerns regarding a patient's capacity, the staff ensured the patient was safe and then undertook a mental capacity assessment. The elderly care consultant attended the ward round on the observational medical unit (OMU) daily and was able to help review the capacity of older patients when there were concerns regarding dementia or delirium.

### Learning from experiences, concerns and complaints

Information was available for patients to access on how to make a complaint and how to access the patient advice and liaison service (PALS). A dedicated member of staff within the A&E team reviewed all formal complaints received and concerns raised with PALS. All concerns raised were investigated and there was a centralised recording tool in place to identify any trends emerging. Learning from complaints was disseminated to the whole team in order to improve patient experience within the department. For example, one patient whose tooth had fallen out had come to A&E. The trust's A&E department was unable to provide emergency dental care or to treat the patient. The patient raised concerns that staff were not forthcoming in supporting them to access the specialist treatment they required. Since the incident, the team have identified what measures should be put in place to minimise the trauma to the gums and increase the chances of a successful outcome for the patient. This learning has been incorporated into the guidance regarding dental treatment at the department.



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## Are accident and emergency services well-led?

Outstanding



Staff reported feeling proud to work in the A&E department. They told us it was “a great place to work” and they had a “very supportive” staff team.

### Vision, strategy and risks

Staff were knowledgeable on the trust’s vision and were aware of the priorities for the department. Information was available to all staff on the trust intranet about the trust’s vision and strategy and staff were aware of how to access it. They were provided with updates on any changes or amendments to the department’s priorities and performance against those priorities.

Staff reported feeling supported by the department. The executive board were visible and engaged in ensuring the department was meeting patients’ needs. The chief executive visited the department weekly and additionally if the department had been particularly busy: for example, were unable to receive any ambulances. The chief executive acknowledged the hard work undertaken by the team and provided feedback and recognition of the team’s performance.

A risk register was available for the department and fed into the trust-wide risk register. The management of diabetic ketoacidosis was on the risk register because there was a difference in practice between the trust staff and newly qualified medics in the management. This was due to the trust’s policy being different to the teaching provided to the junior doctors during their training. The trust reviewed their policy in line with best practice guidelines and it was decided it was a safe practice to continue with adherence to the trust policy. Information was disseminated to the team to remind all staff to follow the trust policy and an incident report was to be completed if trust policy was not followed.

### Leadership and culture

There was a flat hierarchy within the A&E department. Staff felt they were able to escalate their concerns to more senior members of staff and were listened to within the department. The nurse lead attended the end of the staff nurse meeting to get direct feedback and to listen to

any concerns they had and suggestions for improvement. Staff were aware of where to go to for support and there were structures in place to support and engage staff at all levels. Staff were able to contact senior members of the team out of hours if they needed further support or advice. The medical team had the phone numbers for the consultants within the department and felt able to contact anyone within the team. One of the junior doctors told us, “I would be happy ringing any of the consultants on their mobile ... as I know they wouldn’t mind.”

We observed the staff working together as a team. We observed the senior registrar teaching and supporting junior doctors and medical students. It was identified that a junior doctor did not record some information on the electronic patient recording system and the doctor in charge explained why it was necessary for the information to be recorded and how it could have an impact on the rest of the department and staff team if the information was missing. The doctor was clear, informative and supportive in providing the junior staff with information regarding processes and procedures within the department.

During our unannounced inspection, we observed, that despite the department being busier than usual during our announced inspection that the senior registrar took the time to explain to junior doctors what treatment patients required and supported them to make decisions regarding patient care.

### Staff training and competency

Staff were given central trust training, as well as training specific to the A&E department, to ensure they had the skills and knowledge to support patients within A&E. Nursing staff had a pathway of progression through the department starting with working in majors and progressing to work in all areas of the A&E department including resuscitation. Nursing staff had their competency tested before they were able to work in all areas of the A&E department unsupervised. One-to-one training was provided to further support staff who needed it to achieve the required competency levels. Mentorship and preceptorship programmes were in place to support newly qualified staff. Staff’s training requirements were reviewed annually and staff attended external courses to continue with their professional development and undertake higher education courses.



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Protected time was provided for internal teaching sessions. Once a week a member of staff led a teaching session to share knowledge throughout the team. For example, one staff member was providing a teaching session on catheterisation. The manager told us this allowed the team to “work to their [staff’s] strengths”.

### Learning and improvement

Staff told us there was a ‘no-blame culture’ within the team. If they made mistakes or something went wrong, this was seen as an opportunity to learn and improve practice. They told us there was a “‘what can we learn from it’ attitude”. Staff told us there was an expectation for staff to get involved in undertaking audits and to identify how practices and procedures could be improved. The findings from audits were discussed at the

department’s quality group and learning was implemented within the department. For example, a staff nurse had undertaken an audit on head injuries and found improvements were needed in regards to the observation of patients. All staff were reminded to use the neuro-observation guidelines with patients with a head injury.

The department had regular quality and safety meetings and the minutes from the meeting and learning from audits was shared with all staff and stored on the intranet for staff to access.

Every six months, the team reviewed the performance of the department and identified any learning that was required.

# Medical care (including older people's care)

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

## Information about the service

We inspected medical care (including older patients' care) at Homerton Hospital over two days, and we visited some wards again unannounced during one afternoon and evening. In total, we visited eight wards, including the elderly care unit (ECU); Graham Ward (stroke rehabilitation); acute care unit (ACU); Daniel Defoe Ward (winter pressures); Edith Cavell Ward (gastroenterology and rheumatology); Lamb Ward (respiratory and general medicine); Cardiology Ward; and Lloyd Ward (endocrinology, haematology and general medicine). We also visited the discharge lounge and the medical day unit.

We spoke with a total of 40 patients and three visitors, reviewed 26 patients' nursing and/or medical records and spoke with 42 staff from a wide range of disciplines.

Before our inspection, we received data and information that we used to determine our key lines of enquiry. This included information such as a low percentage of venous thromboembolism (VTE) assessments, high use of agency staff, low patient confidence in nurses, poor attitude of nursing staff, and low rates of staff appraisal. We noted the location was compliant with the regulations at the time of our inspection.

## Summary of findings

Patient care was delivered in accordance with patients' needs; however, some documentation about their care, such as managing wound care records, was not adequately completed. Some systems in place to reduce risks to patients, including falls assessments and identifying deteriorating patients, did not meet nationally recognised guidelines.

The level of medical staff cover was good, as were the systems in place to ensure patients received multidisciplinary care. We found there were effective ward handover processes in place. However, on some wards there were at times inadequate levels of trained nursing staff, which meant that patients did not always receive the care they needed in a timely fashion. There was a reliance on bank and agency staff to cover shifts, which was at times to the detriment of patients, including those who needed prompt pain relief and those with dementia.

Patients received compassionate care from well-trained staff who promoted their privacy and dignity. Most patients we spoke with were happy with the care they received, although some patients told us they had not been fully involved in their care, or informed about their progress. We found consultants did not always involve patients or their families in 'do not attempt cardio pulmonary resuscitation' (DNAR CPR) decisions.

The trust had appropriate arrangements in place to monitor the quality of the service, and we found that improvements had been made when there had been

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

incidents or complaints relating to the medical wards. Staff were not always aware of the performance of their ward because the performance dashboard had been implemented shortly before our inspection.

### Are medical care services safe?

Requires improvement 

#### Safety and performance

Before our inspection, some data indicators showed that the trust had a lower than national average percentage of venous thromboembolism (VTE) assessments. This meant some patients were not being assessed for their risk of developing a blood clot. Ward staff we spoke with told us that VTE assessments took place on admission to the hospital in the acute care unit (ACU) and were carried out by the medical team. Staff told us the trust's electronic patient record system logged VTE assessments and ensured these had been completed before staff could add further patient details. Staff we spoke with told us nursing staff checked VTE assessments and ensured they were updated as appropriate.

Patients' needs were assessed including whether they had any allergies. When patients did have an allergy, we found they were provided with a red band so staff could identify this. We found some assessments did not meet recognised guidance. Falls risk assessments were still in use for patients over 65 years despite National Institute for Health and Care Excellence (NICE) guidelines recommending that all patients of this age should be considered at risk.

#### Systems, processes and practices

Appropriate procedures were in place to identify and report allegations of abuse. Staff we spoke with knew what the types of abuse were, and how to report allegations. We found senior ward staff reported concerns directly to the local authority and staff had the contact details to enable them too to do this. Safeguarding vulnerable adults training had been completed by most of the ward staff. Each ward had a performance dashboard that showed that most wards were compliant with the trust's target for the percentage of staff completing safeguarding vulnerable adults training.

When concerns had been identified, we found staff had reported procedures appropriately. For example, we heard directly from a patient about an allegation of abuse they had reported about a member of staff on night duty. We found that staff had appropriately reported these concerns to senior colleagues, who then escalated them to the local authority. The alleged perpetrator had been removed from

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

clinical duties to ensure that the patient remained safe while the matter was being looked into. Staff told us that safeguarding concerns were discussed with the multidisciplinary team (MDT) before they were referred to the local authority.

Wards had designated pharmacists who checked prescriptions to prevent errors in giving the wrong medication. Pharmacists were involved in ensuring a continuous supply of medication. The hospital had systems in place to report medication errors and near misses and all staff we spoke with knew how to report an error. We heard about how medication errors were monitored and escalated to senior managers and safety boards, and the learning that took place so that they did not occur again. We saw work was being carried out to develop a bespoke 'app', based on the hospital's antibiotic policy, to aid safe and appropriate prescribing, and the risks when a patient suffered an allergy to antibiotics.

On each of the wards we visited, we checked the suitability and safety of equipment and the environment.

Resuscitation trolleys on each of the wards had been checked on a daily basis and additional equipment had been supplied when necessary in accordance with medical safety alerts. All the emergency medications were within their expiry dates. We looked at the storage of medication and saw that some of the sterile fluids were in unlocked areas and could be at risk of unlawful contamination. The pharmacy department was carrying out regular audits of safe storage, and increasing the frequency of these on wards where a risk was identified. Other medicines were stored appropriately and medication trolleys were kept closed and locked.

### Learning and improvement

The trust had systems in place to report and monitor incidents including near misses, incidents that resulted in harm, Never Events and allegations of abuse. We found the trust had appropriately reported incidents when they had occurred. Between July 2012 and June 2013, the trust reported 283 patient safety alerts, 36% of which related to medical specialties.

Staff used the trust's electronic reporting system to report incidents, and we found evidence that the trust collated this information and fed back to senior staff any trends or ongoing concerns so that improvements could be made. Senior staff told us they attended weekly meetings, which

included representatives from the trust's risk team, to review all recorded incidents and take forward improvements. The trust had a patient safety committee that reviewed all serious incidents.

The trust had systems to ensure that learning from incidents. We asked ward staff about a Never Event that had been reported in December 2012 in which a nasogastric (NG) tube had been incorrectly inserted. Staff we spoke with on several wards were aware of the incident and were able to tell us about how they had learned from the incident. They told us two staff were now required to check that the tube was correctly inserted, rather than relying solely on medical staff. We also found some wards had an NG tube flow chart on display to prompt staff to follow appropriate procedures.

### Monitoring safety and responding to risk

The trust had systems in the form of colour-coded observation charts to identify deteriorating patients. However, the national early warning score (EWS) was not in use at the trust and therefore the systems the trust used were not as robust as is nationally recommended. Staff told us the trust had plans to implement this; however, the system was not in place at the time of our inspection. Staff told us that escalation of deteriorating patients should occur when patients' observations entered 'red'. We saw some examples when this escalation had occurred, and nursing staff subsequently informed a doctor. The involvement of the critical care outreach team was not available 24 hours a day, seven days a week.

We reviewed a sample of patients' medical and nursing records on most of the wards we visited. We found that some nursing documentation was not being adequately completed, including pressure area care plans and wound monitoring. We found staff did not always appropriately assess patients' pressure areas on a regular basis to indicate clearly whether wounds were improving or deteriorating. Records were not always sufficient to identify when wounds had been re-dressed or when this might be required. Staff we spoke with told us wound management information was provided to staff during the handover, but this was not always documented. We also found some gaps in daily care plan reviews, re-assessments and repositioning charts. This inconsistent record keeping meant there was a risk that patients might receive unsafe

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

or inappropriate care. This risk was further compounded by the high use of temporary staff on some wards such as the elderly care unit (ECU) who would rely more on paper records to understand patients' care needs.

The trust has a Pressure Ulcer Elimination action plan which is overseen by the Pressure Ulcer Working Group. The working group is chaired by a Divisional Head of Nursing and its membership includes practitioners in acute and community settings as well as Tissue Viability Nursing leads. The integrated action plan encompasses improving and standardising documentation, introducing simple care plans which incorporate the SSKIN care bundle, competency based training and education, improved reporting processes (including rapid reviews of any Grade 3 or above ulcers acquired within Homerton's care) and improved communication between acute and community based teams.

### Staffing

On each of the wards we visited we found a good level of medical cover at all times including consultants and junior doctors. Medical staff were regularly visible on wards and staff we spoke with told us this was also the case on days when there was no ward round planned. We found there was an appropriate team of medical staff to cover the hospital at night.

However, we had some concerns about the numbers of nursing staff on some wards, an issue that the trust's chief executive recognised as an area for improvement. Consistently during our inspection we were told by patients and staff that nurse staffing levels on some wards were insufficient, particularly on the ECU. Patients on some wards told us it often took some time for their call bells to be answered. We found that, when temporary staff were used, this sometimes had an impact on the care provided: for example, to those requiring prompt pain relief or patients with dementia who needed care staff who were consistently available.

We checked nursing rotas on five wards for four days before our announced inspection. For one day shift at a weekend on the ECU, we found a nursing ratio of one nurse to 14 patients, and three other day shifts were 1:11, when the ECU nurse to patient ratio should have been 1:7. The ward sister explained that on occasions there was difficulty covering shifts, even with agency staff, and we saw that additional healthcare assistants had been sought when nursing levels were particularly low. The senior nurse told

us that most wards had one or two vacant nursing posts, and that recruitment was ongoing and relatively quick; however, there were more staff vacancies on the ECU and therefore the ward was reliant on more bank and agency nursing staff than other wards.

Lloyd Ward did not have enough nursing staff on occasions and used agency staff to cover shifts. Sickle-cell patients on Lloyd Ward required analgesia to be delivered via a pump to manage their pain; however, agency staff were unable to administer this medication in accordance with the trust's procedures for only appropriately trained staff to deliver this care. On the day of our inspection, two of the three nurses on the ward were agency staff, and we found similar staffing arrangements on the rotas we checked. Patients with sickle-cell disease told us they sometimes experienced delays in receiving pain relief, and some attributed this to the lack of available trained staff.

Nurse staffing on the ACU met the requirements of the trust's policy of a ratio of 1:7; however, we found there was a high number of agency staff on the days we checked, which could compromise the continuity of care. Edith Cavell Ward was also low on nurses on occasion, despite the high dependency of some patients. Staff told us they encountered some problems when trying to ensure adequate staffing levels because of the unavailability of agency and bank staff, despite planning rotas in advance.

Senior ward nurses told us that there was no specific tool in place to ensure staffing levels matched the dependency of patients. Staff told us that the trust was planning to look into the levels of staff, but this had not taken place at the time of our inspection. They told us that they were able to source additional nursing and healthcare assistant staff if the level of dependency increased on the ward; however, we found that on occasions additional staff, such as bank or agency, could not always be sourced, leaving some wards short of staff. Several senior nurses told us that they regularly spent above their establishment hours to ensure that a safe service was delivered. One staff nurse told us that with additional staff their ward was safe; however, staff still did not always have sufficient time to deliver attentive, compassionate care. For example, they were not always able to ensure patients had been shaved when necessary.

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

# Medical care (including older people's care)

Good 

## Using evidence-based guidance

The trust monitored the percentages of patients on each ward who had been assessed for malnutrition and dehydration using the Malnutrition Universal Screening Tool (MUST). It was the trust's policy to ensure that all patients received a MUST assessment, but ward scores showed that screening still fell consistently short of the trust's 100% target. However, we found that patients who needed their food and fluid intake to be monitored had this done appropriately, and also that patients who needed input from a dietician or speech and language therapist received this input in a timely fashion.

The hospital provided rehabilitation for acute stroke patients and most patients were repatriated from other local hospitals after receiving initial emergency treatment from a local hyper-acute stroke unit. Patients were not assessed in the acute care unit (ACU) but transferred directly to the ward at the point of transfer. The Graham Ward stroke rehabilitation unit had been audited against the Sentinel Stroke National Audit Programme (SSNAP) to compare practice in a number of domains that included swallow screening, speech and language input, rehabilitation goals and staffing. The stroke ward manager told us that the trust performed well against similar trusts and we saw that, overall, the trust was in the upper quartile of 190 sites nationally.

## Staff, equipment and facilities

We found on some wards we visited that senior staff had revised the skills mix to ensure their wards could meet the needs of higher dependency patients.

Senior staff on each ward told us that they had access to all the equipment they needed, including specialist items when necessary. When equipment needed to be ordered, staff told us this was sourced quickly and without unnecessary delay. We found ward environments to be clean and hygienic on the days of our inspection, although some areas became cluttered when equipment was in use. We found the winter pressures ward was a poorer environment than other wards, but we found patients experienced no difference in the care being delivered because of this.

## Multidisciplinary working and support

The trust had systems in place to ensure that patients' needs were assessed and care was appropriately planned and delivered. Patients' needs were assessed in the ACU to determine whether they needed to receive treatment or be discharged, or whether they needed to be admitted to an appropriate medical ward. The trust had systems in place to ensure that older patients were appropriately fast-tracked to ensure they received appropriate care. The on-call consultant geriatrician visited the A&E and the ACU daily to ensure older patients were either discharged or admitted to the ECU depending on their needs.

We found good examples of multidisciplinary working and handovers across the medical wards we visited. The handover and patient review systems on the ACU were particular areas of good practice, because of the arrangements for the medical assessment of surgical and orthopaedic patients. The ACU also had good systems for on-call consultants and handover. The ACU had three daily handover meetings in which the multidisciplinary team (MDT) provided updates on their patients. There were also appropriate systems in place to ensure the medical wards were appropriately covered by doctors during the night. This included a 'hospital at night' team and an on-call consultant. The therapists and allied health professionals we spoke with gave us examples of how they were involved throughout the night with providing patient care.

We attended a morning handover meeting on the ECU; the meeting involved the full MDT team including therapists and representatives from the social work team, and it was led by a junior doctor. The meetings included the likely date of discharge which the MDT was working towards, but we noted the meetings did not discuss whether patients had a DNAR CPR in place. The trust told us discussions about patients' DNAR CPR took place after daily ward rounds, however we were unable to verify this.

## Are medical care services caring?

Good 

## Compassion, dignity and empathy

On each of the wards we visited, we found staff provided compassionate care and staff interaction with patients was good, including during the delivery of patient care and when supporting patients during mealtimes. We observed

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

medicines administered to four patients and saw that they were given with patience and explanation. Most patients we spoke with were complimentary about the care they received. One patient's relative on the ECU told us, "The care of my dad here has been fantastic and staff have looked after him really well." They went on to add, "There is always someone you can talk to." One patient on the ECU told us, "I am well looked after. I have been given support to eat and help from a physiotherapist." The adult inpatient survey found that the trust was about the same as other trusts on patients reporting noise at night from both other patients and from staff. However, patients told us that sometimes their experiences during the night were not so positive. One patient on the ECU said, "Night staff are grumpy" and another said, "I dread the nights as they are so short of staff." Another patient's relative told us that, when they had raised concerns about the hospital at night, the staff had listened and implemented some changes as a result.

We also had feedback from patients on other wards. Three patients we spoke with were happy with the care they had received on the acute care unit (ACU). Two told us they were happy with the support they had received from the doctors and nurses, but one patient told us they hadn't been kept informed about what was happening to them. Two out of three patients we spoke with on Lloyd Ward were very happy with the care they had received. One patient told us it was "the best ward in the hospital". Patients told us staff attended to them quickly if they needed assistance, but that they did not always know what was happening: for example, when they could expect to be discharged. One patient we spoke with on the Cardiology Ward told us the care they were receiving was "extremely good", that they "get lots of attention" from staff, and staff communicated with them regularly.

### Involvement in care and decision making

We spoke with staff and some patients' relatives about how decisions were made when patients lacked mental capacity. Staff told us that consultants assessed patients' capacity when this was required: for example, to establish whether patients were able to make their own decisions in respect of discharge arrangements. We checked some patients' medical records to evaluate whether the trust had acted in accordance with the Mental Capacity Act (2005). We found patients' capacity had been appropriately assessed and best interest meetings convened when appropriate. We found best interest meetings involved the

multidisciplinary team (MDT) and patients' relatives as appropriate. We found appropriate procedures were in place for one patient who received care and treatment under section 2 of the Mental Health Act 1983.

The Homerton is located in the Borough of Hackney in east London, which has a population of 45% non-white minorities. We found that on medical wards the staff ethnicity mix generally reflected this diversity and the trust had made arrangements to ensure the service it delivered took account of this: for example, by offering culturally diverse meals. We found some examples where patients had been provided with an interpreter when their medical needs needed to be discussed, and some patients received advocacy support when this was needed. On some wards, there was information about the types of support available for a variety of faiths; however; we found no information available on the wards in different languages, although we were told this could be provided if needed.

We saw that local voluntary groups visited the stroke rehabilitation ward on a regular basis to provide support to patients including reading services. Advocacy services were available including Independent Mental Capacity Advocates (IMCAs) for patients who lacked capacity and had no one else to represent them. Staff we spoke with were aware of how to access these services for patients.

Overall, patients were cared for and treated in a way that promoted their privacy and dignity: for example, staff closed patients' curtains when they delivered patient care. However, we noted on the ACU a staff x-ray monitor positioned in a way in which patients and visitors could see it. We also noticed on occasions that handovers took place in areas near to patient beds, which on occasions was not appropriate. Patients were in all cases treated in single-sex areas, including in the ACU, to promote their privacy and dignity.

**Are medical care services responsive to people's needs?**  
(for example, to feedback?)

Good 

### Vulnerable patients and capacity

The trust had a plan to manage the anticipated increase in patients requiring admission over the winter months. This

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

included the opening of a 'winter pressures' ward, Daniel Defoe Ward. We found this ward was appropriately staffed and medical cover was provided by consultants from other areas of the hospital relevant to the needs of individual patients. Patients on the ward were medically stable, and there were also post-operative surgical patients. The ward did not have dedicated therapists but patients were provided with this service in other areas of the hospital. On the day of our inspection, the ward was not at capacity, and we found admissions were appropriately considerate to the needs of patients. For example, staff told us that if possible the ward tended not to accommodate older patients, so they could be more appropriately cared for in the elderly care unit. Staff also told us the ward had sufficient pharmacy cover and all the equipment that was required, and that no complaints had been received from patients on the ward. We noted the environment was poorer on the winter pressures ward than on other wards in the hospital, and patients did not have access to bedside televisions.

We found in most cases that patients were admitted to the most appropriate ward according to their medical need, and during our inspection we came across only one medical outlier on a surgical ward. We found this patient received appropriate intervention from an appropriate consultant, and outlying patients were routinely monitored on the trust's daily site report.

We observed mealtimes on three wards we visited: a lunchtime on Graham Ward, and an evening meal on Edith Cavell Ward and the elderly care unit. We found that overall patients received the support they needed to eat, and drinks were available. Patients who required support with eating and/or drinking were identified by their food being served on a red tray.

The ECU had some dementia initiatives in place including three dedicated dementia care assistant posts to specifically engage and stimulate patients with dementia. Unfortunately however, two of these posts were vacant. We found the one dementia care assistant provided stimulation and engagement to patients on a one-to-one basis during our inspection. The ECU had a dementia room that included appropriate memory-provoking items; however, we found throughout our inspection that this room remained closed and locked. The trust could ensure this room remains open and accessible to patients: for example, to benefit patients who liked to walk around, or

who might prefer a quieter environment. We found most staff on the ACU and the ECU had completed some form of dementia training to ensure they could support patients with these needs appropriately.

The physical environment of the ECU was good and it had recently been refurbished. It was difficult to identify patients who had dementia, and we felt the trust could make use of a dementia identifier, such as the 'forget-me-not' or 'this is me' initiatives recommended by the Alzheimer's Society. This was of particular relevance given the high number of temporary staff working on the ward.

### Leaving hospital

Discharge planning on each of the medical wards we visited usually began when patients were admitted to the ward. We found regular handover and multidisciplinary team (MDT) meetings were discharge focused, and staff discussed potential estimated dates for discharge. Staff told us that patients were involved in the discharge process and we found staff had discussions with patients to confirm relevant arrangements. However, not all patients we spoke with felt fully informed about their discharge. We found that, when a patient lacked capacity to make decisions about their discharge, medical and nursing staff acted in accordance with the Mental Capacity Act (2005) in assessing their capacity and making decisions in the patient's best interests.

The trust had systems to monitor the number of discharges through the site report which was published three times a day, and therefore to monitor the availability of beds throughout the hospital. The trust had a discharge planning team and specific posts to facilitate discharges: for example, a day of discharge co-ordinator who visited relevant wards and the discharge lounge to ensure all relevant arrangements were in place before patients left the hospital. When complex discharges took place, relevant social workers were involved to ensure patients had, for instance, suitable care packages in place.

Staff told us that the number of delayed discharges had fallen within the past year from around 15 to 20 per week to between five and 12 per week; however, ward staff told us they still encountered delays including the timing of transport and medication. When delays in discharge medication had been identified, the pharmacy department had implemented new systems and were continuing to review processes and procedures for dispensing take-home

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

medicines. The pharmacy dispensing target had recently reduced from 2 hours to 1 hour 50 minutes. Despite some problems with discharge, during our visit we found that patient flow at the hospital during a busy time of the year was well monitored and managed.

The hospital had systems to obtain medicines out of normal working hours and all patients we spoke to knew how to access emergency medicines. We heard that sometimes there was a delay in the discharge process and the pharmacist told us how two pharmacists had been nominated to visit wards from Monday to Friday in the afternoon to facilitate the prescribing and dispensing of discharge medicine, so that patients did not have to wait. We heard from staff on two wards that they would like access to longer pharmacy working hours so that patients could have more ready access to discharge medicines when they had surgery at the weekend.

### Learning from experiences, concerns and complaints

There were appropriate systems in place at the trust to ensure complaints were appropriately acknowledged, investigated and responded to in accordance with the trust's complaints procedure. We found some patients made complaints directly to Patient Advice and Liaison Service (PALS) who were based near to the main entrance of the hospital. We received mixed feedback from patients about their experiences of PALS and the complaints service at the trust, including negative feedback from some patients who attended our listening event. However, we saw some examples of how improvements had been made as a result of direct patient feedback: for example, staff training in the use of hearing aids on the ECU.

Senior ward staff on most medical wards were able to tell us about any recent complaints that had been made and how these had been responded to and learned from. For example, on one ward, a complaint had been made about cleanliness and an alleged lack of attention given to a patient. We heard the complaint was discussed with the staff team during a ward meeting and staff were reminded to complete comfort rounds and to ensure call bells were within reach.

### Are medical care services well-led?

Good 

#### Governance arrangements

Most staff we spoke with on medical wards knew about some of the trust's methods to assess and evaluate the quality of the service including service-based audits, such as pressure sore audits, record keeping audits, and meetings to discuss incidents and trends.

Staff submitted regular information to the trust, which the trust used to collate data about each ward's performance in areas such as infection control, assessments, falls, pressure ulcers, training and staffing. We found that a summary of each ward's performance was collated into a ward performance dashboard that highlighted performance during 2013. Each of the wards we visited had received this information, but only one ward, the elderly care unit (ECU), displayed the information for staff, patients and visitors to see. Staff told us the trust had only recently collated the information in such a format, and that subsequently the awareness of the performance among non-senior staff was currently low.

The trust had a daily site report that was sent to senior members of staff across the hospital three times a day to inform them of, for example, how many acute care unit (ACU) beds were available, how many patients were medical outliers on surgical wards and how many staff shifts were still to be filled for the following day. Senior staff told us the report was a useful way for them to monitor their specific areas of responsibility, the performance of individual wards and the overall hospital flow from A&E and ACU through to discharge.

#### Leadership and culture

Medical wards we visited were individually led by competent, experienced and well-trained senior nursing staff. Nursing and healthcare assistant staff told us they felt adequately supported by their senior colleagues, and senior staff also told us they were well supported by their immediate line manager and also by other decision makers in the trust. Ward sisters' roles were supervisory to ensure there was a leadership role on each ward. Ward-based staff told us the trust had supported them in working towards further qualifications such as a nursing degree and specialist training when they met patients' individual

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

objectives. The senior nurse told us that appraisal rates for medical ward nursing staff were good and we saw team meetings that had taken place on medical wards to further support and inform staff.

We found that the pharmacy department was well led and there were examples of good clinical leadership. Besides projects on discharge planning, antibiotic prescribing and auditing, the department was currently involved in joint working with London Ambulance Service and Clinical Commissioning Groups (CCGs) to introduce 'green bags' so that patients' own drugs could be brought into hospital safely and transferred safely between different healthcare settings.

Junior medical staff told us they were well supported in their roles. We found across the medical wards we visited that there was a good level of integration of junior doctors and a level of empowerment to lead when it was appropriate for them to do so. For example, we found junior medical staff led some ward handover meetings.

Staff told us they knew who the relevant senior individuals, such as the chief executive and chief nurse, were at the trust, and we heard such senior staff were often visible to staff. For example, we heard the newly appointed chief nurse had carried out some nursing shifts on medical wards and had fed back their experiences. Staff told us they felt this was positive and they anticipated that some of their concerns would be addressed as a result: for example, an increase in nurse staffing levels.

### **Learning, improvement, innovation and sustainability**

The trust had a risk register that highlighted the main areas of risk including those relevant to medical wards. We saw some concerns we found during our inspection had been highlighted by the trust as areas for improvement, such as the experience of patients and staffing levels on some medical wards. Ward sisters told us that in the past they had been invited by the trust to share their concerns, and some nursing staff told us they had raised concerns about, for example, staffing levels over the past year, but the issue had not been resolved.

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

## Information about the service

There were a variety of specialties responsible for delivering surgical services at Homerton Hospital, including gastrointestinal (GI) services and some orthopaedics. The hospital was a regional centre for bariatric surgery, meaning obese patients from the South East of England were referred for laparoscopic (key-hole) weight loss procedures. There were 53 beds for surgical patients.

There were nine operating theatres, including three dedicated to day surgery patients.

Surgical specialties had historically been grouped together under one directorate within the hospital structure. However, 18 months before our inspection, the small team of trauma and orthopaedics were moved into the Integrated Medical and Rehabilitation Services (IMRS) directorate, which included acute medicine. We were told this decision was based on the case mix of orthopaedic patients and the need for a more inter-disciplinary approach to their recovery. The remaining surgical specialties were managed by the Surgery Women’s and Sexual Health (SWSH) directorate. However, for the purpose of this report, all surgical specialties will be discussed.

Patients whose operations were planned attended the pre-assessment clinic before their surgery. This could be the same day as their outpatient appointment or a date to suit the patient. On the day of their surgery, patients came to the surgical centre before going to theatre for their operation. Patients were nursed in the theatre recovery area after their operation before being transferred to a ward or back to the surgical centre if they were to be

discharged the same day. There was also a dedicated unit for day surgery patients, which was located in a different building on the hospital site. Patients were informed where they needed to attend before their operation.

Patients who attended the hospital as emergencies and whose surgery was unplanned were seen in the A&E department. They were then either transferred to the acute care unit (ACU) or straight to the theatre. They were monitored in recovery before being transferred to one of two dedicated surgical wards or the intensive therapy unit (ITU).

We spoke with 11 patients, two visitors and 21 staff including senior and junior medical staff, senior and junior nurses, care assistants, domestic staff and administrative and clerical staff. We visited the pre-assessment clinic, surgical centre, theatres, recovery, the ACU, day surgery unit and the two surgical wards, which accommodated orthopaedic and trauma patients. We observed care and treatment and looked at records. We received comments from our listening event and from patients who contacted us to tell us about their experiences, and we reviewed the performance of the service.

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## Summary of findings

Patients we spoke with during our inspection were positive about the care and treatment they had received. They were complimentary about the staff in the service and felt informed and involved. One patient told us they had chosen to be treated at the Homerton and another patient described it as “fantastic”. The two surgical wards had performed poorly in the Friends and Family test, but action had been taken to improve this. For example, staffing levels had been increased. Patients knew how to raise a concern and complaints were managed in line with the trust’s policy and procedure.

There were systems in place to ensure that patients were kept safe. Patients were assessed before their surgery to ensure this was appropriately managed, and when they were admitted to a ward area to determine the level of nursing required. We found some inconsistency and gaps in nursing documentation, such as repositioning charts, and patients’ preferences had not always been documented.

Patients received effective care that met their needs. Nationally recognised guidelines and pathways were followed and we found evidence of good multidisciplinary working. However, we were made aware that over night a senior orthopaedic specialist was not available. This meant that some patients may have experienced delays in treatment. Theatres were responsive and had appropriate consultant cover overnight and at weekends.

Staff were proud to work for the service and they had confidence in both service and trust leadership. There was an open, supportive culture where staff were encouraged to report concerns and were involved and empowered to make changes. There were clear clinical governance arrangements in place and managers were aware of the risks in their area and what action was being taken to reduce them.

## Are surgery services safe?

Requires improvement 

### Safety and performance

Analysis of data from our intelligent monitoring information before our inspection showed there was a low risk in relation to mortality for patients undergoing surgery. The trust’s mortality rates were better than expected or tending towards better than expected. However, our analysis did indicate a risk in relation to safety and, specifically, the proportion of patients who were risk assessed for venous thromboembolism (VTE). 95% of all patients should be assessed within 24 hours. The surgical service had not met this target in the 12 months preceding our inspection. This meant some patients were not being assessed for their risk of developing a blood clot. In order to improve performance against this indicator, ward managers told us they audited VTE assessments monthly by checking the records for the patients on the ward at the time. If a patient had been prescribed prophylaxis, they checked that this had been written on their medication chart and administered. Prophylaxis is a type of medication given to prevent or treat the condition.

The trust used the NHS Safety Thermometer to monitor risks to patients. This provides a monthly snapshot of potential areas of harm, such as pressure ulcers, falls and catheter-related urinary infections. In the six months preceding our inspection, the two surgical wards ranged from being 84% and 100% harm free. The dips in performance were mainly attributable to new pressure ulcers. Staff told us that the trust was in the process of rolling out training on pressure area care in anticipation of new nursing documentation, which was due to be introduced.

The trust target for screening patients for meticillin-resistant staphylococcus aureus (MRSA) and their risk of malnutrition was 100%. However, we saw the surgical wards did not consistently meet this target.

### Staff, systems and processes

The dependency levels of patients on wards were reviewed daily by ward managers. Staff on all wards told us it was busy, but they could generally provide effective and timely care as long as there were no unexpected staff absences. However, the surgical wards did face specific challenges.

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There was a high usage of bank and agency staff at the hospital. Rates had increased recently due to an increase in full-time nursing staff on one ward, which needed to be recruited to.

Theatres were appropriately staffed and able to increase their capacity, if required. There was sufficient cover from clinical teams on the wards during the day and a surgical registrar was based on site at night. However, there was no orthopaedic medical cover on site at night. Orthopaedic patients were reviewed by the surgical registrar and cared for by the medical teams until the next morning. An orthopaedic consultant was contactable by telephone and, if the patient required immediate surgical intervention, they were transferred to the Royal London Hospital. Staff were unclear why there were no orthopaedic surgeons on site at night, but did not think this had an impact on the safety of patient care because it was rare a surgeon was needed. However, it had a potential impact on the effectiveness of care because those patients experienced delays in being reviewed by the most relevant specialty.

The trust ensured that there was sufficient equipment to enable staff to provide safe and effective care. Ward staff reported that, if a patient required a pressure-relieving mattress, for example, this could be arranged quickly. Theatre staff told us that theatre lists were reviewed carefully and all equipment was ordered in advance to prevent delays in operation start times. However, ward staff did comment that there was a lack of pressure-relieving cushions in the hospital and this meant that some patients had to spend more time in bed than required.

## Learning, improvement and managing risk

We found evidence that risks were monitored and action taken to make improvements to safety. Risks were discussed at monthly clinical governance meetings. Senior staff we spoke with were aware of the risks in their area and described what action was being taken to mitigate them. For example, based on feedback from patients, staffing levels and attitudes on one ward had been reported as a risk. As a result, staffing levels had been increased by one registered nurse each shift to ensure there was an appropriate number of staff to meet patients' needs.

There was an electronic reporting system in place. All incidents were reviewed and investigated by ward managers and/ or matrons. Incidents were also submitted to the team responsible for risk and, when appropriate, staff were advised when a root cause analysis was required.

Any trends or areas for learning were disseminated to staff through emails and team meetings. Theatre teams had a dedicated meeting every Friday when incidents were discussed. Staff told us they were able to raise concerns and report incidents or near misses. The trust produced a monthly newsletter for staff outlining a summary of the incidents that had occurred and any changes that had been made.

## Hospital hygiene and infection control

Patients were protected from the risk of infection. The trust's infection control rates for *Clostridium difficile* (*C. difficile*) and methicillin-resistant staphylococcus aureus (MRSA) were within the expected range when compared with other trusts. To promote safe practices, there were infection control nurses for each area. They were responsible for carrying out audits and disseminating key messages to staff. During our inspection, we observed all areas to be clean and there was hand gel at the entrance to each clinical area and at the end of each bed or outside side rooms. We looked at the performance dashboard for both the inpatient surgical wards we visited and saw there had been 100% compliance in hand hygiene in the six months before our inspection.

Each ward had dedicated domestic staff who were responsible for ensuring the environment was clean and tidy. Patients we spoke with were generally satisfied with the cleanliness of the hospital, but one patient told us their room had only been cleaned every other day.

We saw that there were appropriate systems for the cleaning and decontaminating of equipment, such as mattresses and commodes. When a piece of equipment had been cleaned, a green sticker was applied to show the date it had been cleaned.

We visited the main surgical theatres at the hospital. Staff were able to describe how they prepared the theatre between patients. On days when theatres were not operating, such as audit days, staff were tasked with cleaning cupboards and storage areas. Deep cleans were carried out in accordance with the trust's annual maintenance schedule. At the time of our inspection, the theatres appeared to be well maintained.

## Patient safety

Patients were required to provide written consent before they underwent any procedure, which was obtained by the clinician carrying out the treatment. We looked at

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examples of completed consent forms and saw these outlined what the procedure entailed and the associated risks. These had been signed by the patient and the clinician obtaining consent.

Patients were protected from the risks associated with surgery. Operative checks carried out by theatre teams incorporated the World Health Organisation's surgical safety checklist. The purpose of this checklist was to ensure that consent had been appropriately obtained and was for the correct procedure, and that the necessary checks had been completed before, during and after surgery. These checks were electronic and the team was unable to proceed until all sections had been fully completed. Therefore the checklist was used for every patient undergoing surgery.

The trust did not use the nationally recommended national early warning score (EWS) for monitoring changes in a patient's condition. We were told that the trust planned to implement the EWS charts, but these were not in use at the time of our inspection. Instead, the surgical wards used colour-coded observational charts to check patients' vital signs. The frequency of observational checks depended on the dependency of each patient. These observational charts were used to ensure that patients who may be becoming unwell were escalated appropriately. At night, these patients were reviewed by the on-call team. Staff told us the critical care outreach team was quick to respond and supported them in how to care for patients who did not meet the criteria for admission to the ITU. There was a resuscitation trolley in each ward or clinical area and we saw these were checked daily.

## Nursing documentation

On admission to hospital, nursing staff completed an assessment of a patient's needs. This assessment included their risk of having a fall, developing pressure ulcers, malnutrition and dehydration. When a potential risk was identified, staff were required to complete additional assessments or care pathways to ensure these risks were appropriately monitored. However, during our inspection we found inconsistencies in the way this documentation was completed. On one ward, there were two different assessment tools in use for assessing a patient's risk of developing pressure ulcers which could lead to inconsistencies as it was not clear which tool staff should be using. We also found examples of where monitoring charts had not been fully completed or where the

frequency of observations had changed and it was not clear why. For example, in one set of notes the patient had been assessed as being at risk of developing pressure sores. The frequency they should be repositioned varied between every two and every four hours.

On 2 February 2014, this patient was not turned between 8am and 3.10pm, over seven hours, or 10pm and 10.30am, over 12 hours. When we asked staff about this they were sure the patient would have been repositioned but had failed to record it. We were told that it was the nurses' professional judgement that determined the frequency of when a patient needed to be repositioned. We asked how staff knew, when they came on shift, what care or support each patient needed. We were told each member of staff was given a handover sheet with the list of tasks required and that bedside handovers also took place. However, one patient on Priestley Ward told us that handovers had not taken place at their bedside and thought that it would improve care if patients were involved. The inconsistencies in documentation meant there was a risk that some patients did not receive appropriate care when they needed it to ensure their safety and welfare.

## Ward rounds

Patients from all nine surgical specialties were cared for on the two surgical wards. Therefore, there were nine ward rounds each day, which nursing staff told us was "challenging" because it was not always possible for a nurse to attend each ward round when they were busy. They relied on the doctors informing them verbally of any key tasks that needed to be undertaken for each patient, such as blood tests or a change in medication. However, if the doctor only wrote their instructions in the patient's medical notes, then nursing staff may not look at these for some hours later. Therefore, care was not always co-ordinated and there was a risk that care or treatment was delayed.

## Medicines management

We found that medicine was not always stored appropriately in some areas. On Priestley Ward, the medicine storage area was not secure and could be accessed by unauthorised patients. While most medications were stored in locked cabinets, intravenous fluids were not and the drugs fridge was unlocked. The drugs fridge temperature was recorded daily, but staff were unable to find the records for February 2014. The most recent temperature recording available for us to view was

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from 22 January 2014. We spoke with the pharmacy team who informed us they were aware of the storage arrangements in this area and were monitoring the risks. They were in the process of piloting new storage arrangements on Thomas Audley Ward where all medications were stored securely and appropriately.

In the theatres we found that general and local anaesthetics were being stored together. It is recommended that these items are stored separately.

## Vulnerable patients and capacity

There were systems to protect patients from the risk of abuse. Safeguarding training was mandatory for all staff and attendance was monitored through each area's performance dashboard. Staff were able to describe the process should they have a concern, and they knew how to find the relevant contact details on the trust's intranet. This included informing their line manager, the trust's safeguarding lead and making a referral to social services. However, we noticed that there was a lack of information on display for patients who wished to raise a concern.

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

Good 

## Using evidence-based guidance

Evidence-based guidelines and pathways were used by surgical services, including the fractured neck of femur (hip fracture) pathway and the enhanced recovery programme for orthopaedic and colorectal patients. Both aim to improve the speed of recovery and long-term outcome for patients following surgery.

The trust had also signed up to the Anaesthesia Clinical Services Accreditation (ACSA), a voluntary programme run by the Royal College of Anaesthetists, which aims to drive improvements through a programme of peer review.

## Performance, monitoring and improvement of outcomes

The trust participated in a variety of national clinical audits to measure its outcomes, including bariatric surgery and fractured neck of femur. There are particular timescales providers should meet for patients with hip fractures to ensure they have the best possible outcome, such as carrying out x-rays, providing pain relief and operating

within 24 hours. According to the 2012/13 national neck of femurs audit, the trust was in the top 25% nationally for the management of pain and reviewing and prescribing pain relief. However, only 10% of patients were x-rayed within 60 minutes, which was a reduction from 30% since 2008.

Based on fractured neck of femur guidelines, a surgical rehabilitation team (SRT) was launched in April 2013. The SRT was a team of physiotherapists and nurses, led by a consultant geriatrician providing a holistic approach to recovery from theatre. The trust conducted a study on the effectiveness of the team and since June 2013 the average length of stay for hip fracture patients had decreased to below the national average. The SRT worked closely with the Homerton orthopaedic outreach team (HOOT) who visited patients in their homes to ensure they had sufficient support and the correct equipment.

Our analysis of data from our intelligent monitoring information before our inspection indicated a risk in relation to the effectiveness of the service with regard to emergency re-attendance following both elective and emergency procedures. The trust carried out an audit to determine the reason for the high figures and found that some patients had been classified incorrectly, while others could have been prevented with better discharge planning. The audit also identified patients who presented with unrelated medical conditions, especially gall stone-related disease. The audit recommended the creation of a "Hot gall bladder" service to manage such cases. At the time of our inspection, this had not been implemented. However, we were told that there had been improvements in the level of information patients were given before they were discharged and this included a 24-hour helpline whereby patients could speak to a nurse if they had any concerns. Patients we spoke with were satisfied with the level of information they had. One patient who was about to be discharged confirmed they had been given post-operative advice.

Based on benchmarking data from Public Health England, the trust had more orthopaedic surgical site infections than expected. As a result, it restricted knee and hip arthroplasty to two surgeons so they became the most experienced in these procedures and could reduce operating times in order to lower the risk of infection.

## Staff, equipment and facilities

Ward managers told us that it could be difficult to ensure there was the correct skill mix of staff on each shift to

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provide appropriate care because they were responsible for patients from nine surgical specialties. They told us they reviewed skill mixes daily and allocated patients to staff with the most appropriate skills and knowledge. However, they felt that more clinical supervision and training that would increase staff knowledge and skills on the surgical specialties they came into contact with would help nursing staff provide more effective care.

Theatres were appropriately staffed and able to increase their capacity, if required. There was sufficient cover from clinical teams on the wards during the day and a surgical registrar was based on site at night. However, there was no orthopaedic medical cover on site at night. Orthopaedic patients were reviewed by the surgical registrar and cared for by the medical teams until the next morning. An orthopaedic consultant was contactable by telephone and, if the patient required immediate surgical intervention, they were transferred to the Royal London Hospital. Staff were unclear why there were no orthopaedic surgeons on site at night, but did not think this had an impact on the safety of patient care. However, it had a potential impact on the effectiveness of care because those patients experienced delays in being reviewed by the most relevant specialty.

## Nutrition

When patients were admitted to a ward, they were assessed for their risk of dehydration and malnutrition and had their intake monitored accordingly. The hospital operated a protected mealtime policy whereby patients were allowed to eat undisturbed and ward staff were able to provide one-to-one support to those who required assistance. We received mixed feedback from patients on the food. There was a variety of choices available in order to meet cultural and religious needs, including halal, kosher and Caribbean food.

## Multidisciplinary working and support

The trust encouraged multidisciplinary working. Multidisciplinary team (MDT) meetings took place regularly. For example, the surgical rehabilitation team and the Homerton orthopaedic outreach team (HOOT) met twice weekly. The consultant geriatrician also worked closely with surgeons when treating older patients. In the patient records we looked at, we saw evidence of input from a variety of specialties, including physiotherapists, dieticians and the acute pain service.

## Are surgery services caring?

Good 

### Compassion, dignity and empathy

The trust used the Friends and Family Test to gather patients' experiences. According to the October 2013 test, the two surgical wards were among the worst performing in the trust in terms of whether a patient would recommend the service to others; this was for a variety of reasons, including staffing levels and staff attitude. However, the response rate was low with an average of 35% for the trust, but staffing levels has come up a number of times. The 11 patients we spoke with during our inspection told us they were satisfied with the level of care they had received and felt it was a good hospital. One patient told us they had chosen to be treated at the Homerton rather than their local hospital, while another said staff "can't do enough for you". When we asked staff what they were most proud of, they told us it was the care they tried to provide to patients. One manager told us he was most proud of the "commitment of staff".

Most patients were treated with dignity and respect. We observed staff engaging positively with patients, supporting them with their care in a kind and dignified way. One patient was anxious and distressed, but staff spoke sympathetically and managed to reassure them. Thomas Audley Ward cared for both men and women, but it was divided into single-sex bays and there were designated male and female toilet facilities. We also observed a patient undergoing a surgical procedure who was not covered in a way that respected their dignity.

### Involvement in care and decision making

Patients were supported to make decisions about their care and relatives were involved when appropriate. There were interpretation and advocacy services available to support patients during their hospital stay. Patients who attended a pre-assessment appointment were asked whether they needed an advocate or interpreter present when they came for their surgical procedure, so that this could be arranged by staff in advance. Staff had access to a telephone-based translation service for unplanned admissions and when an interpreter could not attend in patient. Patients we spoke with felt fully informed and knew what their plan of care was.

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## Care planning

We found there was a lack of documented evidence to show that care planning was patient centred and included a patient's psychological needs and patient preferences. Nursing notes documented the care that had been provided, but they were task orientated rather than detailing how the patient liked to receive care. Some notes recorded a patient's religion, but not their preferences: for example, in relation to food. If risks had been identified, such as poor mobility or falls, the patient was put onto a specific care plan to ensure these risks were appropriately managed. However, these care plans were generic and not patient centred.

## Trust and communication

During our inspection, patients were complimentary about the nurses and their attitude. They felt their questions had been answered and that staff at all levels had taken the time to talk them through the process. Overall, patients thought that communication from staff was good. One patient told us, "At the start of each shift staff tell you who they are and explain that they will be looking after you."

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

Good 

## Access to services

The service monitors the number of cancelled operations (both elective and emergency) for non-clinical reasons. Between 4 November 2013 and 4 February 2014, no operations were cancelled, which indicates that patients who needed surgery had their operations as planned. Patients we spoke with who had undergone an elective surgical procedure told us all their outpatient appointments had been on time and their surgery had taken place as scheduled.

During the day, there was a dedicated list for emergency patients from 8am until 8pm and one dedicated theatre for obstetrics. We were told that, if elective lists finished early, emergency cases could be accommodated in order to

reduce waiting times. The trust also occasionally carried out elective procedures on Saturdays in order to meet the national target for treating patients within 18 weeks of referral to the service.

Surgical patients were cared for on dedicated surgical wards. The bed occupancy rates for the hospital were lower than the national average and staff stated that there was a good flow of patients in and out of the hospital. The theatre teams reported that there were occasionally delays in moving patients from recovery to the wards because patients on the wards had not been discharged.

## Orthopaedic and trauma

Patients who required emergency surgery accessed the service through A&E and the acute care unit (ACU). Out of hours, all patients except orthopaedic patients were reviewed by a member of the surgical team. We were told that there was no orthopaedic medical cover based on site out of hours, but that a consultant was available by telephone. This was not in accordance with national guidance. Some staff described this arrangement as "strange", while others told us the system worked. They said the medical team based in the ACU would manage the patient's pain until they could be seen by the orthopaedic team the following day, but if necessary the patient was transferred to the Royal London Hospital.

Surgical specialties were required to send the theatre team their operating list the day before, in order to support the smooth running of the service. However, we were told the orthopaedic team did not confirm their list until the day itself. We were not given a conclusive answer as to why not. We looked at an orthopaedic theatre list for the day of our inspection and saw that the status remained "unconfirmed". This meant that the order of patients was unknown by theatre teams, which could lead to delays if specific equipment or instruments were required. It also meant that some patients may have been 'nil by mouth' for longer than required.

## Meeting patients' needs

Patient's needs were assessed when they attended their pre-assessment appointment and/or once they were on a ward. Staff in the surgical centre told us that, if particular risks were identified, such as a high body mass index (BMI) or blood pressure, the theatre teams were alerted by email to ensure this was taken into consideration in the planning of theatre lists and ordering of equipment. Anaesthetist rotas were available to staff in pre-assessment and so the

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anaesthetist booked for the operation was also informed of any clinical concerns. Surgeons were responsible for deciding on the order of their lists. We were told patients were prioritised according to their clinical needs.

Some specialties staggered the arrival time of patients undergoing elective procedures to minimise the time that they were nil by mouth. However, other specialties asked all their patients to arrive at 7am, meaning they would potentially be nil by mouth for longer than required. Staff told us that this sometimes made patients agitated and upset. In order to mitigate this, staff contacted the anaesthetist to find out if a patient could have liquids.

According to the Adult Inpatient Survey, CQC, 2012, patients did not feel their pain was managed appropriately. Pain was monitored and scored as part of routine nursing observations. Patients we spoke with told us they received pain relief when they needed it. One patient said, "Pain relief is brilliant. They come as soon as I call." There was also an acute pain service, which routinely saw orthopaedic patients, bariatric patients and anyone with unmanageable pain.

Staff we spoke with were aware of their responsibilities under the Mental Capacity Act 2005 and were able to describe what action they would take if they were concerned about a patient's ability to make decisions in relation to their care. We saw a documented example of a patient who had refused treatment despite staff explaining the potential risks of doing so. A capacity assessment was arranged to determine whether the patient had capacity and this was carried out by a psychiatrist.

Patients undergoing surgery were taken to the theatre reception before going to the anaesthesia room. This area contained four beds and one chair. While curtains were available to divide up the area, the two middle beds were touching and patients' privacy and dignity could not be maintained in such a cramped space. Staff told us that patients did not spend long in this area, but they were unable to tell us what the average length of time was. At the time of our inspection, one patient who was distressed was waiting there for over 20 minutes.

## Leaving hospital

The discharge process was started as soon as a patient was admitted to hospital. When patients required additional support post-discharge, referrals were made to social services or the district nurses team. Staff told us those

patients who needed social service support sometimes experienced delays because they had to wait for a social care assessment. The type of support requested and the medication prescribed were included in the patient's discharge summary letter. Staff told us they only discharged patients who were well enough and at a time of day that was safe for that patient. For example, they did not discharge older patients at night unless they had someone to support them when they got home.

Patients we spoke with confirmed their discharge had been discussed with them. When patients had not yet been given a proposed discharge date, they understood the reasons why.

## Learning from experiences, concerns and complaints

The service encouraged feedback from patients and their relatives through the Friends and Family test. The results were displayed prominently in ward areas showing what had been changed as a result of their comments. For example, on Thomas Audley Ward, patients had made negative comments about the attitude of nursing staff, especially at night, high workloads and inconsistent knowledge of some specialist conditions. An in-depth review was undertaken of the issues raised and an improvement plan initiated. A variety of actions were taken including increasing staffing levels, managing individual poor performance and arranging for specialist training to assess staff competencies.

The service had an effective complaints procedure. Staff attempted to resolve issues as they arose, but were aware of the escalation procedure if they were unable to. Complaints were logged, investigated and responded to in line with the trust's procedure. All complaints were discussed at weekly team meetings and monthly governance meetings. Patients we spoke with were aware of how to make a complaint.

## Are surgery services well-led?

Good 

## Leadership and culture

Staff were proud to work for the service and most shared the same opinion of the leadership, at both service and trust level. They told us it was strong and they had

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confidence in senior management to make the necessary changes. We were told that, until recently, there had been an absence of management at divisional level. Staff acknowledged there were still outstanding issues to be resolved, including the use of agency staff and recruiting to vacant posts, but most staff felt the current management team would make the necessary improvements.

Staff told us they worked in an open culture where they were encouraged to raise concerns and report incidents. All staff we spoke with, including agency staff, knew how to report incidents and were aware of the trust's whistle-blowing policy. They told us they would feel comfortable using it. Staff felt emotionally supported.

We spoke with junior doctors and trainee anaesthetists who felt well supported in their roles. The anaesthetists described their induction as strong and well run. They also praised the surgical centre and felt theatres ran like "a well-oiled machine" as a result of how they were managed.

## Monitoring risks and governance arrangements

There were 10 days a year dedicated to clinical and non-clinical audits. These fed into the clinical audit and effectiveness committee, which examined trends and considered ways to improve patient pathways and experience. The committee also looked at outcome data, complaints and particular case studies.

The surgical service kept an up-to-date risk register that was reviewed at monthly clinical governance meetings. It covered all aspects of the service, including staffing, feedback and commissioning. Management staff were able to describe what was on the risk register and what action was being taken. Incidents were reviewed weekly at both service and trust level. Where necessary, root cause analyses were undertaken or the trust commissioned investigations. Audits and service risks were also fed into the quality improvement committee.

## Patient experiences, staff involvement and engagement

Staff at all levels told us they felt able to discuss any concerns or anxieties with their manager. They felt engaged

and some felt empowered to make decisions and improvements, such as increasing staffing levels based on the needs of patients. Ward managers met with the chief nurse monthly, but they also felt able to contact her at other times if they had concerns. The chief nurse had also worked shifts on the surgical wards to experience the issues first hand. Staff felt the executive team was visible and approachable. However, it was commented that this did not also apply to the non-executive directors. Senior staff within the surgical service told us they would not know who they were and said they should be more engaged.

The service actively encouraged feedback through the Friends and Family test from patients who used the service. During our inspection, we found evidence that the procedure was in place and all complaints were monitored routinely as part of the governance arrangements.

## Learning, improvement, innovation and sustainability

In the Department of Health NHS Staff Survey, 2012, the trust performed worse than expected for the number of staff who had their appraisal in a 12-month period. All staff we spoke with told us they had recently been appraised. At the time of our inspection, the rate of appraisal was just over 80% and this was one of the service's performance indicators.

Mandatory staff training was monitored. The performance dashboards for each area provided a monthly snapshot of training attendance. Staff we spoke with felt they received sufficient training, but ward managers felt that more clinical supervision and training would be beneficial.

Weekly staff meetings took place for each area and there were additional learning sessions. The theatre team had a protected hour-long multidisciplinary meeting every Friday morning to discuss logistics and complaints, and to reflect on cases.

# Intensive/critical care

Safe	Good 
Effective	Good 
Caring	Good 
Responsive	Good 
Well-led	Good 

## Information about the service

The critical care service at Homerton University Hospital NHS Foundation Trust incorporated the intensive therapy unit (ITU), high dependency unit and the critical care outreach team. Nine beds were available across the two units. The unit was open plan with two single rooms, one at either end. The critical care outreach team assisted in the management of critically ill patients throughout the hospital.

Staff provided care and treatment for adult patients with life-threatening illnesses or following surgery. Patients were received from A&E, theatres and wards throughout the hospital.

We spoke with one relative, one patient and six staff, including consultants, doctors, nurses and managers over our two-day inspection. We observed care and treatment and reviewed medical records.

## Summary of findings

Patients' needs were being met by the service, and people were cared for in a supportive way. There were criteria for admission to the unit run by the intensive care staff and the critical care outreach team. Patients received safe care and were treated according to national guidelines and evidence-based practices. Patients and their families told us they felt the unit was safe and the care they received was "excellent".

Staff used clinical governance methodologies such as audits to monitor the quality and outcomes of their patients. They reported incidents so they could improve on the quality of care patients received. Risks were monitored and there were processes to ensure patients received care and treatment that was as risk free as possible, and to prevent the spread of infection.

There were enough trained staff and enough equipment to provide care to patients. Staff said they were supported to perform their roles and well led by their clinical leads. They told us, "We have a good team." We observed them being respectful, kind and caring.

# Intensive/critical care

## Are intensive/critical services safe?

Good 

### Safety and performance

Patient safety was ensured in various ways. The service published a quality and activity report every three months that focused on learning from incidents, infection control and patient experience feedback. For example, there had been reported medication incidents. Staff had looked at reasons why these had occurred and actions had been put in place to minimise the risk of further incidents. Medical staff attended monthly quality and academic meetings and ensured feedback of incidents were disseminated throughout the trust to improve the service.

### Learning and improvement

Staff knew how to report incidents and were encouraged to do so. Any serious incidents were fed into the governance system. Staff received feedback from incidents through the trust intranet and email system. Feedback from patients, relatives and staff in other hospital areas was used to improve practice. For example, one patient's family had commented that the transfer from the intensive care unit (ITU) to a ward had been difficult. Action was taken by giving further training to ward staff. Quality meetings were held monthly in the critical care unit. Serious incidents, delayed discharges and new policies had been introduced by the service and these were disseminated to staff through a newsletter.

At the quality meeting a recent national patient safety alert regarding was discussed, a similar event had happened in A&E with a patient and this was picked up very quickly by ITU staff, which showed staff learnt and responded quickly to ensure the safety of patients.

### Systems, processes and practices

There had been incidents with medications. A medication audit had been conducted at six-monthly intervals between May 2012 and January 2014. Results showed that some prescribed medications had not been administered. The action plan suggested that the layout of the drug chart be changed so it was easier to use. The medication policy was also updated and further audits carried out to ensure the changes had been made and to check there had been a reduction in the medication incidents.

There was a critical care outreach team available daily from 8am until 4pm, and they were responsible for reviewing deteriorating patients and transferring them to the ITU, when necessary out of hours a senior on call doctor was available.

### Monitoring safety and responding to risk

The unit participated in the Intensive Care National Audit and Research Programme (ICNARC). This programme audits the mortality and morbidity rates of intensive care patients nationally. The unit reported data to the programme and from the results they identified risks to their patients. One of these was patients being at higher risk of acquiring infections. However, rates of infection were relatively low compared to other ITU because staff effectively screened patients for infections when they were admitted to the unit.

We observed appropriate standards of infection control, such as staff practising hand hygiene when moving between patients. We observed, and saw records of cleaning schedules. The unit was cleaned regularly. Infection control practices of staff were monitored and audited to ensure patient safety. The unit was complying national guidance to ensure the service was being provided in a clean environment.

There were appropriate levels of staff to provide care. Any shortages to staffing numbers were covered by agency nurses who were trained in looking after critically ill patients and regularly worked on the unit.

### Anticipation and planning

All staff attended quality meetings twice a year where patient safety, risk, complaints, audits were discussed. Improving outcomes for patients by trying new initiatives for example, cardiac output monitoring devices. Near misses were discussed to ensure they did not become incidents in the future. For example it was reported that there was a lack of dialysis machines when all three were in use and a fourth machine was urgently needed.

# Intensive/critical care

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

Good 

### Using evidence-based guidance

There were criteria for admission to the unit was in accordance with national guidelines that were followed by staff and the critical care outreach team. The unit monitored and reviewed their data and at the time of the inspection the most recent data showed that an effective service was being provided that met the patients' needs. For example the mortality rate was statistically similar to other ITU, patients were only transferred out of the unit for clinical reasons and re-admission to the unit was low - 0.7% within 48 hours of discharge.

Recommended evidence-based practices were used to provide care, for example, national guidelines on infection prevention. Retrospective audits of unplanned ward admissions to ICU and cardiac arrests on wards were undertaken to measure the effectiveness of staff in identifying sepsis.

### Performance, monitoring and improvement of outcomes

Clinical outcomes were audited by a nurse who was the lead for reporting data to the Intensive Care National Audit and Research Programme (ICNARC). Results from ICNARC were used to help improve patients' mortality outcomes in the ITU. For example, staff were able to improve on delayed discharges of patients by ensuring there were fewer inappropriate admissions to the unit. They also used the results to improve clinical outcomes for patients in relation to their past medical history. Patients would be assessed on the wards by the critical care outreach team and doctors would then decide if the admission was appropriate.

There was a critical care outreach team available daily from 8am until 4pm, and they were responsible for reviewing deteriorating patients and transferring them to the ITU, when necessary out of hours a senior on call doctor was available.

### Staff, equipment and facilities

An analysis of the skills needed to provide care on the unit had been completed by senior staff. Permanent nursing staff told us they received mandatory training, a

supernumerary period and competency assessments when they started in their roles. Appraisals took place at 12-monthly intervals. Staff were asked for a self-assessment of how they had helped to improve the quality of the service. All agency staff working on the unit were required to complete an induction programme.

We saw that equipment had been checked and labelled appropriately, and was up to date with servicing. Staff told us that they had initial training in the use of equipment, followed by regular updates, which ensured they were able to use the equipment safely. Staff were supervised when they needed to learn about a new item of equipment to provide care to patients. We saw that staff were competent in using the equipment.

## Are intensive/critical services caring?

Good 

### Compassion, dignity and empathy

We observed staff caring for patients in a kind and professional manner. They explained procedures to their patients even when the patients were sedated. Visitors to the service were spoken to with dignity and respect. Privacy was maintained by the use of curtains. We observed a family being assisted to see a relative whose condition had deteriorated, and staff explaining what had happened. Relatives told us that they were given access to a quiet room and that the staff were caring.

### Involvement in care and decision making

Doctors and nurses used the Mental Health Capacity Act 2005 'best interest' guidance to decide on care and treatment for their patients. Whenever possible, they discussed all care and treatment of a patient with a family member before making decisions. This ensured involvement of families with their relatives' care. We saw documented evidence of communications with families by doctors and nurses.

### Trust and communication

Relatives and patients were kept informed effectively about their care and treatment. We saw people being updated on their condition. One patient's relative told us doctors had discussed all aspects of "their plan of action". Families were encouraged to contact the unit staff at any time if they wanted to.

# Intensive/critical care

## Emotional support

Staff told us that due to the serious nature of the patients' they were looking after they found it difficult to ask people to complete the Friends and Family test. However, feedback they had received showed patients found the transition from the ITU to the wards difficult, because the one-to-one nursing care was not available on the wards. Staff told us that they were looking at ways to ease this transition, such as promoting more independence as the patient got closer to being discharged. ITU staff had adapted the patient experience strategy to collect data that helped to improve patient care and the service in general. Follow-up clinics, telephone conversations and comments from patients who had returned to the unit to say thank you were used to obtain feedback.

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

(for example, to feedback?)

Good 

## Meeting patient's needs

Patients' needs were being met by the service, and patients were cared for in a supportive way. Their vital sign observations were carried out hourly and recorded. We saw staff acting quickly on information from observation monitoring. Nursing staff told us doctors were always available in the event of emergencies.

A pressure ulcer audit was carried out and the results showed that patients were developing pressure sores from equipment, such as mouth sores from breathing tubes. The dressings used with the breathing tubes had been changed to reduce the likelihood of patients developing these sores. Monitoring of all equipment that could cause additional skin deterioration had been introduced. We saw risk assessments that told staff how to reduce and prevent such deterioration.

Staff provided nutrition and hydration through a regimen of intravenous fluids and specialist feeds. This was with the support of the dietician service, which supported patients who were not able to eat and drink while they were critically ill. We observed all fluids and feeds recorded on observation charts. Doctors used these records to decide on patients' fluid and nutritional needs.

## Vulnerable patients and capacity

Consent was sought from patients if they were not sedated with medication. Family members were also asked to consent to medical procedures a patient needed. Staff had undertaken safeguarding of vulnerable adults training. They were able to explain what this meant for their patients and visiting members of the public. Safeguarding concerns were raised with senior members of staff and the hospital's safeguarding team. These were referred to the relevant local authorities and investigated.

## Access to services

The average bed occupancy in the unit was 86%, which was higher than the national average of 83%. However, these occupancy levels did not affect the quality of care provided. Patients accessed the service from other areas of the hospital and from external hospitals. If, after assessment, it was decided that a patient needed specialist medical care, then they would be transferred to an appropriate hospital. This was the case for patients requiring cardiac services.

The ICNARC data showed that of 398 admissions, there were no non-clinical transfer out of the trust's critical care unit. This meant patients were not moved from the ITU because the bed was needed for other patients.

## Leaving hospital

The unit monitored any readmission of patients and reported this data to the ICNARC. Patients were discharged to other areas around the hospital. Most patients were transferred during the day however around 2% of patients, based on 273 admissions were discharged out of hours. This percentage is lower than most other ITU. Based on 344 admissions, around 58% of patients were subject to a delay of four hours or more when discharged. This is slightly better than the national average.

A follow-up clinic was available and ITU staff invited patients and their relatives to attend so they could hear and respond to their feedback. This feedback was also used to improve the service. For example, patients reported that they often felt tired during visiting times. Visiting hours were adjusted to enable patients to have adequate and timely rest to aid their rehabilitation.

## Learning from experiences, concerns and complaints

Patients were asked to give feedback on their experience of using the ITU service. Relatives had complained about the front door bell not being answered promptly when they

# Intensive/critical care

came to visit. Staff ensured that administration staff were available during visiting hours to open the door as often as feasible. On the day of our visit, we observed the door bells being answered promptly.

## Are intensive/critical services well-led?

Good 

### Governance arrangements

Clinical governance systems were effective and staff were able to explain how this had an impact on patients. Patients received care and treatment according to national guidelines and this was monitored. There was a comprehensive audit programme that focused on quality. We saw the process for risk assessment that was specific ITU staff and patients.

### Leadership and culture

The provider may find it useful to note that the Faculty of Intensive Care Medicine (FCIM) recommends that the service employs a specialist in ITU. The service did not follow this recommendation, instead the service rotated on a daily basis senior anaesthetists. We saw that this did not pose a risk at a unit of this size. We observed junior doctors taking up their posts in the unit on an ITU induction training day.

Each consultant was a project lead for an audited area, which meant responsibility for service improvements was clear. All staff told us that they were supported by senior levels of staff when they started their post on the unit. The staff were relaxed and professional. The unit culture was conducive to learning and development.

### Patient experiences, staff involvement and engagement

Staff told us the service was well led. One staff member said, "I feel supported to look after my patients." Another said, "We have a good team." Each consultant had a clinical area they led on: for example, research and development. Consultants worked well together and we saw them updating each other on patients' conditions.

### Learning, improvement, innovation and sustainability

All staff received mandatory trust training and updates. Topics included basic life support and infection control. Junior doctors rotated through the service and received good support. Nursing staff were seconded on specialised intensive care courses. Practice development nurses were available in the unit and worked with junior nurses to develop their learning within the service.

# Maternity and family planning

Safe	Good 
Effective	Good 
Caring	Good 
Responsive	Good 
Well-led	Good 

## Information about the service

Homerton University Hospital NHS Foundation Trust provided maternity care for more than 6,000 women and their babies each year, during pregnancy, labour, birth and up until one month after birth.

During pregnancy, the trust offered both midwifery-led care (at the hospital and in the community) and consultant-led care (based at the hospital). Midwives offered care to women at the hospital antenatal clinic, at local GP surgeries and children's centres, and at the Shoreditch Maternity Centre.

'A midwife-led birth centre with four birthing pools was located alongside a 13-bedded labour ward with a triage area. There was a five bedded Obstetric Assessment Unit, a 46-bedded postnatal ward, a maternal fetal assessment day unit and a seven-bedded antenatal ward located close to the labour ward. The trust also provided a home birth service. There was a 46-bedded postnatal ward, a maternal fetal assessment day unit and a seven-bedded induction suite located close to the labour ward. The trust also provided specialist pre-conception advice for women with certain long-term medical conditions.

We spoke with 30 women, 25 midwives, eight managers, five doctors, two domestic staff, a house keeper, a porter and reception staff. We received two comment cards.

## Summary of findings

We found that the maternity and family planning services were safe. Women were protected from avoidable harm. There were effective systems in place to ensure the care delivered met people's individual needs. Staff had appropriate training and followed standard operating procedures as well as relevant guidance to deliver care.

Staff were caring and described by women on the maternity wards as "approachable" and "attentive" However, there were a some negative comments about the attitudes of a few midwives at night.

The trust served a diverse population and was responsive to people's needs by initiating several initiatives such as bilingual maternity support workers and a pilot project for "husband/partners staying overnight"

Staff were aware of the trust's values and vision and felt supported by senior management to report incidents without the fear of being blamed. Several midwives told us they had chosen to work at the Homerton because of the support and professional development they received, even though it was not their local hospital.

# Maternity and family planning

## Are maternity and family planning services safe?

Good 

### Safety and performance

We found that between July 2012 and July 2013 the trust had a considerably higher emergency caesarean section rate (20.2%) when compared with the national average (14.5%). The population served was high risk with many women accessing care at a late stage. The trust had improved its emergency caesarean rates in August to December 2013, it had reduced to 18.02% and there were ongoing monitoring measures in operation. Both midwives and obstetricians told us that the circumstances each case of a woman presenting at a late stage was looked into to prevent this happening again.

### Learning and improvement

Staff told us that serious incidents such as unexpected admission to the neonatal intensive care unit (NICU) were discussed and they had action plans to address concerns. Some were due to failure to escalate and had been addressed by shared learning with the midwives on different escalation protocols. Staff and managers told us there were several initiatives to ensure that staff were aware of incidents that had happened at the hospital and in other maternity units. This was done through various newsletters such as “Tips of the Fortnight”, during mandatory training and at interdisciplinary and local team meetings.

### Systems, processes and practices

The trust had effective systems to ensure that infection prevention and, medicine management protocols were followed and that resuscitation equipment was in working order. An early warning scoring systems to identified patients whose condition may deteriorate was used and this was audited to ensure that staff were completed this accurately and patients were escalated appropriately. Resuscitation checklists were completed daily in the clinical areas we visited. Medicine trolleys were kept locked and secured to the wall, and controlled drugs checks were completed appropriately.

There were enough midwives to provide safe care. The ratio of midwives to women was in line with the national recommendation 1:28. However the majority of midwives

we spoke with reported that they did not always have time to take their breaks. They felt this was a potential risk in providing safe care and had raised it with the management team. Consultant cover was available on the delivery suite for 80 hours which complied with the recommendations of Safer Childbirth. The trust had funding to provide cover for 98 hours from October 2014 depending on the appointment of staff.

### Monitoring safety and responding to risk

Recently there was a maternal death where a mother died following a haemorrhage after a caesarean section. All staff we spoke with were aware of the incident and learning had been cascaded effectively by debriefing sessions with staff, newsletters, and case study-based learning. Midwives informed us that the latest evidence-based guidelines, the ‘Maternity Risky Business’ newsletters, mandatory training and email reminders were added to the intranet.

## Are maternity and family planning services effective?

(for example, treatment is effective)

Good 

### Using evidence-based guidance

The rate of women with puerperal sepsis was categorised as an elevated risk by the CQC in October 2013 and the trust was alerted by CQC about this. Clinical audits carried out following the alert from CQC reported that all the cases included in the audit had been appropriately managed and identified that coding of diagnosis was inconsistent. In response to this, clinical staff met with clinical coding and data quality staff to develop an improvement plan. Staff were in the process of developing local guidelines to identify and manage puerperal sepsis. Daily senior ward rounds for postnatal patients were introduced and junior medical staff received training in writing discharge summaries to enable them to assign the correct diagnosis and improve subsequent coding.

### Performance, monitoring and improvement of outcomes

The outcomes for women and their babies were monitored by various committees and forums. The Strategic Executive Information System (STEIS) records serious incidents and Never Events. Between December 2012 and November

# Maternity and family planning

2013, 22 serious incidents relating to maternity services occurred at the trust. These were 13 unexpected admissions to the Neonatal Intensive Care Unit (NICU), three maternal unplanned admissions to the intensive care unit (ITU), and two occasions when suspension of maternity services occurred. There were also two unexpected neonatal deaths, and one maternal death. On our inspection, we found that most staff were aware of these incidents. There was evidence that showed investigations and learning from the incidents had taken place. For example, regular audits were completed on the use of the early warning scoring system on the postnatal ward in order to ensure that midwives used this tool to recognise and escalate a deteriorating woman or baby. The audits showed that the midwives had improved at recording and escalating a deteriorating mother or baby and that they were following the hospital's procedures.

## Staff, equipment and facilities

Staff told us they were equipped and up-to-date with their training. A training needs analysis outlined the competencies needed to provide effective care. A training dashboard was maintained that recorded the courses attended by staff at different levels and alerted staff and their managers when training was due.

The maternity training strategy, including the maternity dashboard showed that participation rates in all training for midwives, maternity support workers (MSWs) and doctors were at 90% or above in January 2014.

## Are maternity and family planning services caring?

Good 

## Compassion, dignity and empathy

The CQC survey of women's experience of maternity care (December 2013) results rated the trust as 'worse', compared with other trusts, in the following areas: labour and birth, and staff and care in hospital after the birth. However, on our visit, we spoke with 30 women told us of positive experiences of their birth, the staff and after-birth care.

The trust's Friends and Family test (a test to see whether women would recommend the hospital to their friends and family), based on responses from 26 women in December

2013, also had positive findings on their care during birth. We observed care in progress and found positive interactions between staff, women and their families. Women thought the midwives were caring. One woman in the postnatal ward said the midwife had offered to look after the baby for four hours so she could sleep. We also received positive comments on comment cards, at the midwives focus group, and at the listening event. The only negative comments were from two women relating to the attitudes of staff at night, and another from a woman who had paid for a side room in order to stay because her baby was still in the special care baby unit. We explored this further during our unannounced visit and found no further concerns.

## Involvement in care and decision making

Women told us they had been involved in planning their care. We saw birth plans and documented evidence in women's antenatal notes that showed women were involved in their antenatal care. Those who preferred water births and were assessed at low risk of developing complications had been supported to have their chosen birthing method. Other women told us that, although they had been scared, they were informed when induction of labour had 'failed' and had been involved in their care and decisions as to the next steps. We spoke to a woman in triage who had used the service for seven of her pregnancies and births, and also supported other women from her community as a doula. She said, "Homerton maternity care is now better than ever. Of course the building is too small but the staff are wonderful."

## Trust and communication

The trust set up a group for women who had had one previous uncomplicated caesarean section. These women were encouraged to attempt a vaginal birth following their caesarean (VBAC). They were identified at their first antenatal or booking appointment, booked into a 'birth after caesarean' session run by the consultant midwife between 20 and 24 weeks' gestation and given a copy of the 'birth after caesarean section' booklet. The session outlined the options for women who had had a previous caesarean with an expectation that the women would attempt a VBAC. The consultant midwife also offered the women strategies to assist them in having a successful VBAC.

# Maternity and family planning

## Emotional support

Bereavement midwives at the hospital offered support to women after the loss of their baby. We saw the Angel room – a facility that was used by bereaved women and their families. Staff told us that this room was used often to allow families to spend time with their baby before taking the deceased baby to the mortuary. This enabled families to say goodbye and gave them time to accept and begin to adjust to their loss.

The trust worked with Bliss, a charity that supports parents who have babies in the neonatal or special care baby units. One woman told us the staff had been supportive and she could go and see her baby on the special care baby unit. Breast feeding support was available and women told us they had been supported to breast feed and to express milk.

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

Good 

## Meeting people's needs

In recognition of the diverse population served, the trust had community-based bilingual maternity support workers (MSWs) working alongside midwives. The bilingual MSWs helped to improve access to maternity services for women who did not have English as a first language. At the time of our inspection, MSWs in post covered the needs of women who spoke French, Lingala, Mandarin, Cantonese, Polish, Portuguese and Turkish.

A “partner staying overnight pilot” was completed on the postnatal ward where partners were allowed to stay overnight. This was done to improve father and child bonding and to support the mothers during the first few hours after birth. As a result of the pilot, further changes, such as better signage and a dress code for partners, were suggested and in the process of being implemented.

The trust introduced outpatient induction of labour (IOL) in 2007, and this was offered to all low-risk women who required IOL for prolonged pregnancy. The pathway was adapted to enable community midwives to offer

membrane sweeps to women from 40 weeks' gestation in the community. Women who went into labour following the first dose of prostaglandin could choose to continue to labour in the midwife-led birth centre.

## Vulnerable patients and capacity

Support was available for women identified to have mental health issues or substance misuse problems at the booking clinic. There were specialist midwives to offer care to women with HIV and other sexual health illnesses that could affect the baby.

## Access to services

The trust closed the maternity services once in 2012/13. Although its average bed occupancy was within the Royal College of Midwives guidelines, it was significantly above the average for England and may have reflected the diverse requirements of the population who used the services; for example, some women could not or did not access care until late in pregnancy and had high-risk factors that affected their length of stay.

The hospital ran a twice -monthly Wednesday club for overweight pregnant women in order to increase awareness of the potential risks associated with obesity in pregnancy. The sessions were jointly facilitated by a consultant obstetrician, consultant anaesthetist, consultant midwife in public health and a senior dietician. The sessions built on the written information contained in the trust's information leaflet for pregnant women with a high body mass index (BMI).

Access to maternity services was also provided through a maternity telephone helpline that was available from 10am till 6pm, seven days a week. The helpline advised women who were booked or wanted to book at the trust for their pregnancy. We found that it was staffed by experienced midwives who had specific training about domestic violence, confidentiality, and handling difficult and emotional calls. The helpline was commended by a stakeholder whose role was to represent the experiences of women using the trust's maternity services.

## Leaving hospital

Staff told us about a newborn examination clinic that had been operating since 2012 in order to improve the discharge process for postnatal women. The seven day a week clinic was jointly run by neonatologists and midwives who had completed the newborn examination course. This helped to improve the discharge process for women and

# Maternity and family planning

their babies. The clinic had also improved interdisciplinary working relationships, with the neonatal team supporting the midwives to maintain their confidence and competence in completing the newborn examination.

## Learning from experiences, concerns and complaints

Senior managers told us the complaints process ensured all complaints were reviewed, adjusted and signed off by the chief executive, the chief nurse or the medical director. Complaints data were also reported regularly to the board of directors. There was evidence that the trust had learned lessons and actions had been taken to avoid episodes described by women happening again. For example, breast feeding support had increased as a result of complaints made by women on the postnatal ward.

Maternity matrons had met a group of women in December 2013 who had given birth at Homerton in July 2013 to discussed poor breastfeeding support on the postnatal ward. The trust responded by increasing breastfeeding support on the postnatal ward to ensure that women would be enabled to breastfeed successfully before they left and would be provided with advice of who to contact in the community if further support was required.

## Are maternity and family planning services well-led?

Good 

## Vision, strategy and risks

The vision had recently been redeveloped and was displayed in clinical areas. Staff understood how this vision and the trust's values applied to their daily work. At senior level, the risks were clear and actions to be taken were known by and the responsibility of named individuals known as risk owners. In October 2011, the trust was found compliant at level 2 of the clinical negligence scheme for trusts (CNST) risk management standards. This showed that they had good risk management systems in place.

## Governance arrangements

The governance framework was clear, well understood and functioning to support delivery of high-quality care. Staff at ward level knew what happened when they reported incidents or raised concerns, and they told us they were usually given feedback once issues had been escalated

according to the trust's incident reporting and safeguarding protocols. Clinicians told us there was a named consultant lead who attended governance meetings and fed back to the staff teams.

## Leadership and culture

Midwives, doctors and family planning nurses told us they reported incidents without blame and were aware of the processes in place should they need to whistle blow or raise any concerns about the quality of care delivered. However, since July 2012 we have had contact from correspondents who said they were a group of midwives who were whistleblowers. Our contact with them has been by email and they have maintained their anonymity. They made allegations of racism and poor leadership not only of the maternity services but of the trust as a whole. They had also raised allegations about the trust covering up avoidable deaths of newborn babies. In February 2013 we inspected the maternity services at the trust and did not find evidence to substantiate their allegations. The trust carried out internal reviews to address their concerns but found no evidence to substantiate them. The Clinical Commissioning Group (CCG) completed an external review which they had not published at the time of writing this report.

During our inspection we held focus groups for maternity staff which were well attended. At this inspection, we found no evidence to support allegations of racism or poor leadership. We did invite the group to come to CQC to meet with us to discuss their concerns but it was not possible to arrange a meeting. We have said they can contact CQC in the future if they wish to. We will continue to monitor the trust with respect to their reporting of untoward incidents and where concerns are raised.

## Patient experiences, staff involvement and engagement

The trust had various initiatives to improve women's experience. A supplementary breast feeding clinic on the postnatal ward was introduced in October 2013. The "Baby friendly" action plan was updated and the trust was working towards stage 1 baby friendly accreditation in December. We spoke to the maternity service liaison committee (MSLC) chair who felt the trust engaged with both the MSLC and the diverse population, and responded to their needs.

The Friends and Family test was introduced in the maternity department in October 2013 and results, from a

# Maternity and family planning

small sample size, were positive about the care received antenatally, during labour and after birth. The Antenatal and New-born Screening Education Audit showed the trust met three of the principal standards around education and training. The supervisor to midwife ratio was currently 1:18 and all the midwives we spoke to knew who their supervisor of midwives (SoM) was and felt able to access them.

## **Learning, improvement, innovation and sustainability**

The trust worked closely with the local authority, the CCG and East London NHS Foundation Trust. Innovations included an integrated service which focused on early intervention to improve health and wellbeing and to reduce infant mortality.

Staff were encouraged and supported to be innovative in improving care for continuously improving the care for women and their babies. For example the trust set up a maternity helpline for women to use if they need advice. The helpline operated 10am till 6pm, 7 days per week and there was a voicemail service for patients to leave messages if they call out of hours. All helpline staff were experienced midwives who were trained in domestic violence support, confidentiality and handling difficult and emotional calls. The helpline receives on average 38 calls per day.

# Services for children & young people

Safe	Good 
Effective	Good 
Caring	Good 
Responsive	Good 
Well-led	Good 

## Information about the service

The services for children and young people include a children's emergency assessment unit, a children's outpatients department adjacent to the children's inpatient ward which has 18 beds.

There is a Neonatal Unit consisting of 46 cots. The unit has 16 intensive care cots, 8 high dependency cots and 22 special care cots. The unit is part of the North East London Neonatal Network and is a designated Level 3 unit which means that it admits babies requiring intensive care from other units within the local network including Queens Hospital Romford, King George's Ilford, North Middlesex and Whipps Cross Hospitals'

We spoke with 12 children, 15 parents, nine nurses, three managers, four doctors and received 11 comment cards.

## Summary of findings

We found that children's services were safe; children were protected from avoidable harm.

There were effective systems in place to ensure the care delivered met children's individual needs. Staff had appropriate training and followed standard operating procedures as well as relevant guidance to deliver care. Staff were caring and were described as "loving", "easy to talk to", "very supportive, through a difficult time" and "willing to go the extra mile".

The trust served a diverse population, was responsive to children's needs including services such as City and Hackney Young People Services Plus (CHYPS Plus) which provides holistic health services for young people aged 11-19 years.' Staff were aware of the trust's values and vision, and felt supported by senior management. They told us they could report incidents without the fear of being blamed.

# Services for children & young people

## Are children's care services safe?

Good 

### Safety and performance

We found that patient safety and equipment safety checks were monitored daily by the lead nurses. Feedback on the latest development or incident was given to staff through communication files in the neonatal unit. Staff briefings took place including audit and feedback of results on issues such as infection control, medication administration and NHS Safety Thermometers. However, recent audits relating to areas which had previously been identified by staff as safety issues in the neonatal intensive care unit (NICU) had not been carried out at the time of the inspection.

It is trust policy to screen all children who have been admitted from another care organisation or have been in hospital within the last 12 months on admission'. Meticillin-resistant staphylococcus aureus (MRSA) screen results were published and staff were spoken to regarding missed screenings. Infection control audit results were printed and displayed. Areas for improvement were discussed in handovers, via email and during study days.

### Learning and improvement

There was evidence that learning took place following incidents. We reviewed information sent in by the trust and found that incidents were addressed appropriately. For example a child had received an overdose of morphine due to an incorrect rate on the infusion pump, and the wrong drug was given to a baby due to drugs left unattended at the cot side. Senior management showed us evidence that they had supported staff to improve patient safety by arranging training updates for infusion pump training which had been attended by all staff.

Between October and December 2013, medication incidents were an issue of concern on Starlight Ward. Incidents related to the storage of medicines and medicine errors. Staff were aware that the highest number of incidents related to medicine errors, and they told us that competencies and skills mixes had been reviewed. On Starlight Ward, we saw that infusion pumps had been

replaced with models where volumes could be set at the correct pressure to prevent the risk of extravasation, and staff had been trained to use the new pumps. All medicines were stored in a key-coded room in locked cupboards.

### Systems, processes and practices

Hackney community services told us, and we saw evidence, that the trust contributed to both the children's and adults' safeguarding boards and the relevant borough-wide safeguarding plans. The trust had an up-to-date policy relating to safeguarding children, safe recruitment, work planning, supervision and training, which was accessible on the intranet. Staff were aware of these policies and where to locate them. We saw that an 'allegations against staff procedure' was marked as pending, although the need for such a procedure had been highlighted on the trust's risk register.

Staff were aware of the flow chart for managing alleged or suspected abuse and told us there were named lead professionals including doctors for the acute and community setting, a liaison nurse and health visitor. We also saw how children attending with child protection concerns were flagged up on the computer system and also reviewed by the safeguarding children team using a risk-based rating system.

### Monitoring safety and responding to risk

The neonatal unit reviewed the circumstances surrounding all deaths that were either born in or admitted to the hospital. The reviews included debriefing to staff, initial assessment to define the cause of death, recording of the neonatal death on the electronic incident reporting system and discussion within perinatal mortality forums with the maternity team'. A more in-depth approach to sharing mortality and outcomes had been put in place recently in the NICU, and this was now an extended and additional part of the forum for perinatal and neonatal review and governance.

Information on neonatal deaths was recorded in the unit's monthly activity reporting, which was discussed within the neonatal forums and at NICU governance and consultants' meetings.

# Services for children & young people

## Anticipation and planning

The teams in the children's services worked closely together to ensure patients were being cared for in the most appropriate area. The wards monitored discharges daily and were in contact with bed managers and A&E department to ensure bed pressures were identified early.

### Are children's care services effective? (for example, treatment is effective)

Good 

## Using evidence-based guidance

The NICU had effectively implemented two National Institute for Health and Care Excellence (NICE) guidelines: recognition and treatment of neonatal jaundice (May 2010) and antibiotics for early onset neonatal infection (August 2012). The trust had changed to using the NICE charts simultaneously with the postnatal ward and the Children's Emergency Assessment Unit (CEAU). Trainee doctors were made aware of relevant evidence-based guidance that was in practice. For example, a junior doctor had developed a colour-banded version of the NICE jaundice chart to make it easy to see what action should be taken for an individual bilirubin reading (specific blood test to identify jaundice).

## Performance, monitoring and improvement of outcomes

Starlight Ward had introduced new parent information leaflets that were at the end of each bed and in the parents' room so parents understood the ward routine, knew what to expect during their child's admission and had useful information to help them during their stay. Tympanic thermometers had been introduced. This meant it took about 30 seconds rather than three minutes to take a temperature recording, thereby minimising stress and improving the accuracy of recording.

The Neonatal Unit implemented new charts for the monitoring of neonatal jaundice in line with the NICE guidelines that were in use across the postnatal ward and the neonatal unit. Babiven was also introduced, which is a parenteral nutritional support product for specific use with neonates. We found that clinical governance subgroup meetings were held to discuss root cause analysis of incidents.

## Staff, equipment and facilities

The equipment and environment were clean in all the children's services we visited, with the exception of one bay on the NICU where the issue was addressed as soon as it was raised. Staff were supported to continue professional development including attending relevant study days such as 'Lactation management for neonatal staff' and 'Breast feeding'. There was a senior nurse on duty to support staff and to oversee the nursing care being provided on the ward. Staff had the right skills to be able to carry out their roles. The skills required by staff were continuously reviewed by senior staff.

## Multidisciplinary working and support

A multidisciplinary team (MDT) reviewed medication practices on Starlight Children's ward. Once a week meetings were held to discuss the care of each baby in the neonatal unit. This ensured the management and discharge planning was organised for each baby. A multiprofessional child protection operational forum of children's therapists, psychologists, health visitors, managers and nurses from sexual health, paediatrics, adolescent health and school nursing met twice a month. The forum ensured that the service managers were kept up to date with the number of babies who were on the child protection health register (CPHR) database.

### Are children's care services caring?

Good 

## Compassion, dignity and empathy

We observed the environment was child friendly and nurses spoke to parents in a polite and friendly manner. In the children's emergency assessment unit, the staff had applied child-friendly vinyl décor on the walls. On the children's wards, nurses had built a rapport with the children and their parents. Staff spoke to children with compassion and always knocked before they entered children's cubicles. We observed staff use distraction therapy in order to make children relax before doing procedures such as blood pressure. We also observed staff explaining to children why they needed medication and telling them that it would make them get better quicker.

## Involvement in care and decision making

Parents and children felt involved in the care they received. Parents told us that the nurses always offered choice and

# Services for children & young people

explained the benefits. One parent said, “The nurses are very good at encouraging (a child) to take his medication.” Another said, “I know most of the staff by name. They are very approachable and always willing to help.” We reviewed sick children’s folders on Starlight children’s ward and found that there was evidence of involvement of the parents and the children. Consent forms were signed for by the parents and we saw documented discussions of information given to parents on the progress of their children. The parents we spoke to on the day were aware of discharge plans and could tell us what their children were waiting for.

## Trust and communication

Parents told us that they had been given leaflets on admission and were aware of whom to ask if they had any concerns. Parents and children told us that nurses usually introduced themselves at the beginning of the shift. We observed nurse interactions with parents and children in all the clinical areas were visited and found them to be positive, engaging and child centred. We also found that communication around outpatient appointments and cancellation of appointments was also good.

## Emotional support

There was a counsellor for the families with children in the Neonatal Unit and a support group for parents was held weekly. Parents overwhelmingly told us the nurses and doctors were very supportive. One parent said, “The nurses have been very supportive over a very difficult time while my baby is still in special care.” Another said, “They always seem to know what to do to help Y.” On the day of our visit, we saw a family who had just lost their baby the previous day come in with a gift and card to thank the nurses for the care and compassion given. No parents or children made any negative comments during this inspection.

**Are children’s care services responsive to people’s needs?**  
(for example, to feedback?)

Good 

## Meeting patients’ needs

There was a 10% increase in babies receiving their mother’s breast milk on discharge, which showed an effective breastfeeding support mechanism for mothers. New breast

pumps were being trialled in the NICU and feedback from the women using them would determine which pumps the trust purchased. There was a service for young patients who attended the Children’s Emergency Assessment Unit. This service took a holistic assessment approach. It looked at multiple risk-taking behaviours by undertaking a home, education and employment assessment and considering activities such as, drug taking, sexuality, suicide attempts/ depression, in order to see how to best support the young patients.

## Vulnerable patients and capacity

The named nurses for children’s safeguarding worked closely with the service. They reviewed each A&E discharge summary and made a plan according to the A&E follow-up protocol and their knowledge of the family. The service used a colour coding system to prioritise patients who needed contact from the school nurses. The higher the risk, the sooner the community nurses team made an initial contact with the family and face-to-face contact at school or another venue.

## Access to services

Parents with babies in the NICU attended a weekly parents’ support group in the unit. This was supported by Bliss, a charity that supports families of premature babies. After discharge, there was a community parents’ support group at Hackney Arch, with nursery nurse support from the NICU twice monthly.

Young patients had access to support by means of follow-up by the City and Hackney Young Patients Service (CHYPS) team with regards to their attendance at A&E. There were strong links between the community and the children’s assessment unit. The unit was notified by the children’s community nursing team if children with chronic illnesses had been referred to A&E.

## Leaving hospital

Length of stay in children’s clinical areas had improved because of a more individualised patient approach and extended community service support. There was an ‘improved discharge at admission approach’, which was facilitated by parents’ information packs for admission and discharge, and early referral to the children’s community nursing team.

The system for new born bloodspot notification (a blood test to check for jaundice) and management of results had been reviewed to ensure that all babies were followed up

# Services for children & young people

appropriately. When children or young patients attended A&E, discharge summaries were shared electronically with their GPs and health visitors (0–5 years), school nurses (5–16 years) and the CHYPS (16–18 years).

The trust had identified issues with the communication pathway between acute and community services in relation to the dissemination, receipt and follow-up of A&E summary sheets following the attendance of children or young patients in A&E. This was due to different computer-based systems and was being monitored to ensure the process was more robust.

## Learning from experiences, concerns and complaints

There were 12 formal complaints received and investigated between July and September 2013. Most complaints received related to outpatient appointments (choose and book, waiting times, transport, information) or the phlebotomy service. Work had started to improve the phlebotomy service including moving the service to the wards so that patients awaiting discharge could be prioritised, and putting extra staff on the morning rota to accommodate the early morning rush.

## Are children's care services well-led?

Good 

## Vision, strategy and risks

The trust's vision for children's services had recently been redeveloped and was displayed in clinical areas. Staff understood how this vision and the trust's values applied to their daily work. At senior levels, the risks were clear and actions to be taken by and the responsibility of named individuals known as risk owners.

## Governance arrangements

Senior staff were aware of risks that were on the register and action plans were in place with named risk owners responsible for ensuring actions were completed. We reviewed information sent in by the trust about incidents that had occurred between July and September 2013. There was evidence of trend analysis and documented actions following incidents. Meticillin-resistant staphylococcus aureus (MRSA) remained an issue as very few children fall into the category that need screening. However, action plans were in place on Starlight Ward to

ensure compliance; these included competencies and performance monitoring. The actions plans had been introduced to address issues identified in November 2013 so it was too early to judge their success.

We reviewed minutes of monthly paediatric clinical quality meetings between April and August 2013 and found that issues about quality and clinical effectiveness were discussed and action planned. These included MRSA screening and neonatal deaths. Learning from incidents was discussed and there was a slight improvement in MRSA screening on the NICU.

Monthly governance meetings were attended by consultant paediatricians, and senior nurses identified trend analysis and incidents. Risk assessments were completed and added to the risk register following review at the divisional meeting.

## Leadership and culture

Staff felt that quality was part of the leadership culture and felt able to raise concerns. The service had a quality improvement committee and minutes of these meetings demonstrated regular discussions of issues such as MRSA screening inpatients and visual infusion phlebitis (inflammation) scoring for children receiving intravenous medications. The risk register was regularly reviewed and some risks had been closed when actions had been completed and the risk assessed to be at an acceptable level. Both senior staff and those in the clinical areas knew what risks were on the risk register.

## Patient experiences, staff involvement and engagement

The trust was meeting its targets for reducing term admissions and discharges. Patient feedback was good with the exception of outpatients where issues around waiting times and cancellations were being addressed.

## Learning, improvement, innovation and sustainability

Senior managers told us the complaints process ensured that all complaints were reviewed and signed off by the chief executive, the chief nurse or the medical director. Complaints data was also reported regularly to the board of directors. We reviewed four complaints and found that they were responded to in a timely manner. Issues highlighted, such as last-minute changes to outpatient appointments, conduct of reception staff in outpatients

## Services for children & young people

and missed intravenous medication doses, were addressed. There was evidence that the trust had learned lessons and actions had been taken to prevent episodes described by the patient happening again.

# End of life care

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

## Information about the service

The trust provided palliative and end of life care at Homerton Hospital. It did not have a dedicated oncology inpatient unit. Patients received end of life care across the trust that was provided by a specialist palliative care team. This team was available Monday to Friday from 9am to 5pm, excluding bank holidays, and consisted of a part-time consultant, three nurses, a psychologist, an occupational therapist and an allocated social worker. At the time of this inspection, the post of team manager was vacant. An out-of-hours telephone advice service was available to doctors and nurses at all other times.

We visited six wards: Lloyd Ward, the Cardiology Ward, the Elderly Care Unit (ECU), Graham Ward, Edith Cavell Ward and Lamb Ward. We also visited the multifaith centre, the chaplaincy service, the chapel of rest and the bereavement office. We spoke with eight patients, two relatives and 22 members of staff, including all three palliative care nurses, a chaplain, a bereavement midwife, a mortuary officer and a bereavement administrator. We also spoke with ward managers, staff nurses, healthcare assistants and doctors working on acute medical wards that provided palliative and EOL care. In addition, we received information from patients who attended our listening event and from patients who contacted us to tell us about their experiences, and we reviewed the trust's performance data.

## Summary of findings

Patients received safe end of life (EOL) care. There were systems in place to ensure patients were kept safe. They were given information and support to make decisions about their care as inpatients and they were involved in the planning of their discharges. Patients' individual care needs were being met within the hospital and effective discharge planning took place that used established links with local community services including St. Joseph's Hospice in Hackney. Staff received appropriate training and support, and understood the good practice guidelines and pathways in place. The service was well led by an experienced palliative care team that was respected and valued by medical, nursing and other colleagues in the hospital.

# End of life care

## Are end of life care services safe?

Good 

### Safety and performance

Patients received a safe end of life care service.

Staff showed an understanding of how to protect patients from the risk of abuse. The staff we spoke with were able to identify different types of abuse and knew how to report allegations. They told us they had attended safeguarding and mental capacity training. We found that mental capacity assessments had been carried out when required. All the patients we spoke with told us they felt safe at the hospital and did not have any concerns about the conduct of any of the staff.

Nursing staff told us they received training from the palliative care nursing team about how to safely set up the syringe drivers, which were used for patients needing continuous pain relief. In addition to providing this training, the palliative care nursing team was responsible for checking that staff were competent in their use of the syringe driver. We looked at the records of four patients who were receiving palliative or end of life care. We found their care needs (for example, pain relief, skin integrity, hydration and nutrition) had been assessed by multidisciplinary staff and their care was being delivered in accordance with their identified needs. Patients could be written up for palliative care medications before they needed them, so there would be no unnecessary delay when they were required.

### Learning and improvement

Staff working on the wards and those within the palliative care nursing team told us they used an electronic reporting system to report any incidents. Ward staff described the palliative care team as an important resource for discussing any issues about a patient's safety, and developing improved ways to ensure the safety and well-being of the patient.

### Systems, processes and practices

The patient records we looked at had been completed and important information regarding end of life care was properly documented. Patients' discharge plans were clearly recorded and the patients we spoke with were fully aware of these plans.

### Monitoring safety and responding to risk

The patients' records showed that regular multidisciplinary discussions took place, which included how to meet patients' changing needs. For example, the nursing assessment tool for end of life care required staff to assess and document whether a patient was demonstrating non-verbal indications of being in pain. We also saw assessments by speech and language therapists to establish if patients were no longer able to swallow safely. The palliative care nurses told us they visited patients several times a day if they had symptoms that needed close monitoring, and this was confirmed in our discussions with patients and their relatives. One patient told us that the palliative care team had organised for a hospital-style bed to be delivered to their home as part of the discharge planning, because there were issues of concern regarding the safety of their existing home arrangements.

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

Good 

### Using evidence-based guidance

The end of life care adhered to government guidelines. Following the national independent review, *More care, less pathway: a review of the Liverpool Care Pathway in July 2013*, the trust was no longer using the Liverpool Care Pathway and was in the process of introducing new end of life care nursing documentation in February 2014, which had been developed using evidence-based guidance including that produced by the Leadership Alliance for the Care of Dying Patients. Nurses working on medical wards told us and showed us that they could access specific guidance about how to meet the needs of patients receiving end of life care. The guidance addressed clinical issues such as managing bowel problems, nausea and vomiting, and restlessness.

The maternity unit followed the standard guidelines of the Royal College of Paediatrics and Child Health, and the Critical care decisions in fetal and neonatal medicine (Nuffield Council on Bioethics for End of Life Care). There is

# End of life care

currently a study taking place at the Homerton, in collaboration with University College Hospital, London, to improve the end of life pathway for babies and their families.

## Performance, monitoring and improvement of outcomes

Patients' end of life care was managed effectively. Ward staff told us that the specialist palliative care team responded promptly to referrals, which meant patients experienced an efficient service.

The Cancer Patient Experience Survey 2012/13 indicated that the trust performed better than other trusts on 17 out of 69 questions. There were 23 questions on which the trust performed worse than other trusts nationally. These were around communication with patients, including choice of treatments, financial help, responses to important questions and discussing fears. The National Bereavement Survey (VOICES) 2011 was carried out when the Homerton formed part of the North East London (NEL) primary care trust (PCT) cluster. The NEL PCT performed in the top 60% of all PCT clusters nationally on two of the 26 questions, which included patients feeling that staff dealt with them sensitively after their loved one had died. However, on eight of the 26 questions, the NEL PCT was in the bottom 20% of PCT clusters, which included questions about whether there was sufficient support for families at the time of a patient's death, and whether respect and dignity were always shown by hospital nurses.

## Staff, equipment and facilities

The staff we spoke with were very committed to meeting patient's needs and wishes. One of the palliative care nurses told us how a patient had been anxious to quickly return home to spend time with a relative and this had been arranged. Staff told us they tried to provide a single room for patients receiving end of life care, and this was confirmed by a relative. The nursing staff used a document known as the 'Individualised end of life care plan' for the ongoing monitoring of care. This document required nursing staff to assess whether patients and their families were being cared for in regard to the provision of a suitable environment and suitable equipment. For example, nurses recorded whether the curtains surrounding a patient's bed on a main ward were clean and fitted properly, and whether they had been able to offer a side room.

Ward managers and nursing staff on each of the wards we visited told us they spoke with families about how to access food and drinks within the hospital, open visiting hours and car parking. Healthcare assistants told us about how they offered drinks and blankets to families.

## Multidisciplinary working and support

End of life care within the hospital was provided by the clinical team originally looking after the patient, which ensured continuity of care. The nurses and doctors we spoke with understood the operational policy of the specialist palliative care team and the referral system. Staff told us they felt well supported by the specialist palliative care team. Staff nurses also spoke highly of the support they received from the bereavement team, particularly if they needed advice about how to support patients and their families from different cultural backgrounds.

The palliative care team told us they benefited from good working relationships with staff at the hospital and in the community. For example, the team had been allocated a regular social worker who had experience of supporting patients receiving palliative care and understood their specific practical and financial concerns.

The palliative care team and the bereavement team told us they worked closely together and had regular joint meetings. The bereavement team, which consisted of a full-time chaplain, a bereavement administrator and a mortuary officer, informed us they also had regular contact and meetings with the specialist bereavement staff on the maternity and paediatric units.

The palliative care team had established positive working relationships with community services, including GPs, district nurses and the community palliative care team at the local St Joseph's Hospice. We spoke with a member of the community palliative care nursing team at St Joseph's, who told us there were good joint working practices in place and weekly meetings between the hospital and community teams. However, these meetings had not been taking place at the same frequency for a few months because of the absence of a team manager for the specialist palliative care team.

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## Are end of life care services caring?

Good 

### Compassion, dignity and empathy

All the patients and families we spoke with described the staff as being caring and compassionate. One patient told us, "I am over the moon with the care here. Everyone has been absolutely superb." All the staff we spoke with emphasised how important it was to provide patients and their families with a calm environment and dignified care. For example, one of the staff nurses told us they understood how distressed families could become when a loved one was no longer able to eat and drink. The staff nurse told us they would give explanations and reassurance to families, and show them how regular mouth care was providing moisture and comfort for the patient. The nursing care documentation also advised staff that families could bring in music and photographs, so that they could help to provide an individualised and comforting environment for their loved ones.

The palliative care nurses and many of the ward-based nursing staff told us that the bereavement team played a key role in ensuring that deceased patients and their families were treated with care and respect. Staff on different wards told us of occasions when they had contacted the chaplain, bereavement administrator or mortuary officer for advice and support, and had met members of this team at meetings and training sessions. The chaplain provided 24-hour support for patients and their families and the nursing care plan documentation prompted nurses to check whether this support was needed at any stage of EOL care. The chaplain told us how they had developed local networks with religious ministers of different faiths, which meant hospital staff had current information about how to ensure that the correct practices were followed when a patient died. Throughout our discussions with staff, patients who had passed away were consistently referred to in a respectful manner as 'the patient'.

### Involvement in care and decision making

Patients told us they were fully involved in their care. One patient told us they were being discharged to another London borough, which was not covered by St. Joseph's Hospice. The patient had been fully consulted about their

discharge and was aware of the content of the discussions that had taken place between their palliative care nurse at the hospital and the palliative care team in their home borough.

Patients and their families could get information and leaflets from the Homerton Health and Cancer Information Centre, which was based in the hospital and open Monday to Friday, 9am to 5pm.

### Emotional support

The palliative care team included a psychologist and all the staff we spoke with acknowledged it was their role to provide patients and their families with emotional support. The patient information leaflet developed by the palliative care team informed patients about organisations they could contact and useful websites to visit. The leaflet also told patients about advocacy services, how to make a complaint and how to use the Patient Advice and Liaison Service (PALS).

The chaplain, bereavement administrator and mortuary officer told us about the different types of support they provided to families after the death of a patient. This support included providing words of comfort and prayer, advising patients about the necessary practical arrangements for registering a death and organising a funeral, and ensuring that patients felt welcomed and supported if they wished to say goodbye to their loved ones in a chapel of rest. The bereavement team provided patients with a comprehensive booklet entitled Information and guidance following a bereavement.

The palliative care team and the bereavement team told us there were rarely deaths in the paediatric unit, which had its own specialist staff to support patients with loss and bereavement. The maternity unit also had a team of specialist bereavement midwives who provided support to parents whose babies had died, or who had had a miscarriage, neonatal death or termination for abnormality. The bereavement midwives helped parents to preserve memories (for example, through foot and hand prints and memory boxes), and they provided emotional support during the next pregnancy.

## Are end of life care services responsive to people's needs? (for example, to feedback?)

# End of life care

Good 

## Meeting patients' needs

The palliative care nurses told us they always listened to patients about what was important to them. They told us that many patients wanted to be transferred to their preferred place to die, which might be their own home, a hospice or a nursing home, and they did not want to experience delays with this. The palliative care nurses had built up good relationships with local commissioners, St Joseph's Hospice and the local social services, so that patients' wishes could be met as speedily as possible. Although the full palliative care team is available during the week at present, a palliative care nurse is available on an 'on call' basis during the weekends ensuring the patients' needs are met at the time.

We reviewed 16 'do not attempt cardiopulmonary resuscitation' (DNAR CPR) decisions across five wards we visited. All decisions were appropriately documented and implemented, or signed off by senior medical staff. However, we found 11 of the 16 records did not document that decisions had been made in consultation with patients or their relatives.

The trust audited DNAR CPR decisions in 2012 and re-audited samples in 2013 and early 2014. However, we found that not all the trust's initial recommendations had been implemented at the time of our inspection. For example, including the ceiling of care form with all DNAR decisions was not in place on all medical wards, only on the elderly care unit, and when it was used we found most of the forms did not indicate whether or not the ceiling (for instance how active treatment should be and for how long it would continue) had been discussed and agreed with the patient or their relative.

Patients we spoke with on the medical wards provided mixed responses when we asked them whether they felt involved in their care, or supported to make decisions. Some patients told us they knew what was happening, and that they had been kept up to date by their consultant, but others did not feel this was the case.

## Leaving hospital

The Adult Inpatient Survey, CQC, 2012, identified that patients did not feel staff discussed the equipment or adaptations they would need. The patient records we

looked at demonstrated that patients received assessments from physiotherapists, occupational therapists and dieticians before they were discharged. One patient told us they had been on a home visit with an occupational therapist and hospital staff had also involved the relative who would be their main family carer.

## Learning from experiences, concerns and complaints

The medical wards (including the elderly care unit) set up bereavement support meetings in 2009, in response to families feeling that they had unanswered questions about the end of life care of their loved ones. Letters were sent to families four to six weeks after the patient's death; these offered the condolences of the staff who had looked after them and asked if patients would like to have a meeting with the head of nursing for the medical directorate and the consultant. After the meeting, patients were sent a summary of the discussions and offered an opportunity to make any clarifications via a telephone discussion or a second meeting. The trust's own analysis of the bereavement support meetings identified that approximately 5.5% of patients chose to attend a first meeting and, when necessary, patients ordinarily followed up any remaining queries in a telephone discussion. The head of nursing for the medical directorate told us that patients had reported that the meetings had been beneficial as part of their grieving for their loved one, and they might otherwise have made a complaint because they had not fully understood the patient's condition and end of life care. These meetings also provided the trust with information to improve the experiences of patients and relatives and, if applicable, they could signpost relatives to appropriate counselling services or voluntary organisations.

## Vulnerable patients and capacity

The palliative care nursing team told us they always monitored if patients' capacity to make decisions about their care and treatment had been assessed, when necessary. The guidance for nursing and medical staff also emphasised the need to consult with patients and their chosen representatives in regard to their wishes: for example, their preferred place of death. The palliative care nurses told us they provided guidance and training for staff when patients had made advanced decisions and/or appointed a patient welfare Lasting Power of Attorney.

# End of life care

## Access to service

Members of the palliative care nursing team told us they had the capacity to respond swiftly to referrals. They did not get referrals from the intensive care unit (ITU), which had policies and procedures for supporting patients and their families with end of life care. The wider range of professionals working within the palliative care team (for example, a social worker, psychologist and occupational therapist) meant that patients and their families could more easily access essential support such as counselling, aids and adaptations for discharge, and advice about obtaining statutory financial benefits.

## Are end of life care services well-led?

Good 

## Vision, strategy and risks

The end of life care service was well led and there were systems in place to monitor the quality and safety of the service. The palliative care nurses told us that the service wanted to expand in order to provide visits to patients out of hours, because this had previously been available. The trust had identified the development of end of life and palliative care services as one of their objectives for 2014.

## Leadership and culture

The senior lead for end of life and palliative care was the medical director at the Homerton.

At the time of this inspection, the palliative care nursing team did not have a manager. This was not a long-standing vacancy and the palliative care nurses told us the trust was advertising to fill the position. The palliative care team and the bereavement team were well known to other staff.

Ward managers and staff nurses praised the members of these teams for their knowledge and dedication, which provided positive mentorship and guidance. For example, a ward manager told us that the mortuary officer had been involved in a recent programme of staff training and this had given nursing staff a new and more in-depth understanding.

## Patient experiences, staff involvement and engagement

The patients and relatives we spoke with reported positive experiences of receiving palliative and EOL care. Throughout our discussions with medical and nursing staff on the wards we visited, staff demonstrated that they felt very involved in the provision of good-quality EOL care. Nurses and healthcare assistants told us about the training they had received from the palliative care nursing team and showed an enthusiasm for ongoing training. One ward manager said they had arranged for the palliative care nursing team to deliver a programme of 12 teaching sessions for their ward, because staff wanted this input. Staff liked the system of the palliative care nursing team having designated wards that they covered, because this promoted continuity and good working relationships.

## Learning, improvement, innovation and sustainability

The palliative care nurses told us they were carrying out an audit of the quality of completion by staff of the end of life documents, and recording their interventions within patients' records. Also, the hospital had developed specific arrangements to meet the needs of patients from the local Orthodox Jewish community, and these included an agreement for documents to be signed during the Sabbath.

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

## Information about the service

The outpatients' department was located near to reception within the main hospital site.

The main department and waiting area were located on the ground floor with the fracture clinic and women's outpatients. Because of increasing patient numbers, a newly commissioned and refurbished area was also now in operation on the first floor. The trust ran a wide range of outpatient services every weekday. Specialty clinics included haematology, gastroenterology, rheumatology and ophthalmology.

There were 280 clinics each week seeing an average of 17,000 patients each month.

We spoke with patients and a range of staff at all levels of the trust, and observed the clinic waiting areas and interactions between staff and patients. We received feedback from our listening event and staff focus groups, and patients contacted us to tell us about their experiences. We also reviewed performance information about the trust.

## Summary of findings

The outpatients department was a busy department that provided safe care. The department was clean and well maintained. When clinics were running late, patients were told how long the delays would be and given the reason for them. There were sufficient numbers of staff on duty.

The outpatients department generally met the Department of Health guidelines for ensuring patients received appointments within 18 weeks of referral. Patients told us staff were caring and explained their treatment to them. There were clear lines of leadership in the department and staff knew to whom to escalate concerns.

# Outpatients

## Are outpatients services safe?

Good 

### Safety and performance

The service learned from incidents. An outpatients manager was allocated to every reported incident to clarify, verify and investigate. Outcomes were reported at a weekly trust incident management meeting so that the trust had oversight and managed the risks. Incidents that occurred in outpatients were collected together and analysed every three months by the outpatients managers to identify possible themes and emerging issues. Documentation we looked at demonstrated that issues were explained and learning points identified through this process.

### Learning and improvement

There were several forums available to communicate learning from incidents, events and live issues to staff. A staff handover meeting took place every morning, managers' meetings occurred on a monthly basis and subteams within outpatients (bookings, records, reception and clinical) had team meetings bi-monthly. There was also a group email address for the head of outpatients to use for this purpose. There had been no serious untoward incidents, near misses or Never Events in outpatients. We were given an example of a recent incident that had occurred in another department within the hospital, which had been communicated to outpatients staff as a trust-wide learning exercise. Staff in outpatients were aware of what had been learned from this event.

### Systems, processes and practices

The healthcare records team began preparing the patient records for each clinic a week before appointments. The trust measured the number of records that could not be located and prepared for outpatients, which ran at approximately 8% per month, which was higher than the trust would have liked. Therefore the service was planning to invest in an electronic file detection system to make locating files within the hospital easier. When a record could not be located and prepared, the records team set up a temporary one from the electronic file, which included a patient's details plus recent contact with the hospital, any tests and clinic letters. Consultants we spoke with felt their work was well supported by the role of the records department and patients received consistent care.

### Anticipation and planning

Patients told us they felt there were enough staff available to meet their needs. The nurse in charge was responsible for ensuring the right numbers of staff with appropriate skills were providing care. The number of clinics held each day and the number of patients attending each clinic were used to calculate the staffing need each week. Each clinic discipline, such as fracture or anticoagulation, had staff allocated to morning and afternoon slots. In order to further understand the numbers required, individual clinic needs were considered in the allocation of staffing resources: for instance, the dressing needs of the fracture clinic, and the nursing support and chaperone needs of the endocrine clinic. There was a low turnover of staff within the department, which enabled greater continuity of care. Because of the creation of a second outpatients reception area and more clinic rooms, there had recently been an increase in nursing staffing.

### Environment and infection control

There were clear arrangements in place for the prevention and control of infection. There were regular infection control audits that checked treatment rooms, trolleys and equipment, and the decontamination room. We looked at documented audits and saw that issues (for example, dusty low surfaces and replacing the lock on the decontamination room to ensure restricted access) had been identified, acted on and resolved. Audits carried out in January 2014 showed an overall compliance of 98.7% had been achieved in infection control audits.

Environmental audits carried out by the trust's estates services in partnership with outpatients managers. These had identified overcrowding in the anticoagulant clinic area and this was posing an increased risk to slips and trips and, when the need arose, having to evacuate the building. This had been reported to the trust's executive team through the risk register. The trust had responded to this and had plans to re-locate the clinic to another part of the outpatients department that provided more space.

An environmental improvement plan highlighted further planned improvement to remove potential hazards to patient safety such as infection control, falls and congestion. The plan included upgrading the lighting, some flooring and the consulting rooms, and redesigning the reception area and nursing station.

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The trust had an effective system for reporting and repairing building faults. We saw examples of recent repairs made on the same day they had been reported, such as the fixing of a fire safety heat sensor.

We saw that treatment rooms were clean. Signage promoted hand hygiene, and hand washing facilities and disinfectant hand rub and cream were available. Paper towels, sharps and clinical waste bins were also available for safe disposal.

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

Not sufficient evidence to rate 

### Using evidence-based guidance

The trust was working in partnership with the City and Hackney Clinical Commissioning Group (CCG) to improve outpatients by looking at new ways of working, the environment and productivity. The trust had looked at how it could prevent overcrowding by reducing the high number of follow-up appointments. This included identifying appropriate primary care support with the help of the CCG. Planned work to the environment had begun with an upgrade of the lighting. We were told that reconfiguration of outpatient areas, such as the anticoagulation clinic, reception area and nursing station was planned.

### Staff, equipment and facilities

The outpatients department had a system of staff rotation. This aimed to increase skill levels and motivation among nursing and healthcare assistant staff as well as reducing the cost of bank staff. We were given examples of staff having been trained in particular skills, such as using visual fields and the aseptic technique to enable them to work in different clinics.

There were formal structures in place for staff to receive training and annual appraisals. For example, we saw a log showing that staff had completed mandatory training in e-learning, and we also saw that appraisals had been completed. Staff's performance, learning objectives and how they were meeting values were discussed in appraisals. Staff we spoke with also confirmed they had received training and told us what they discussed in appraisals.

## Are outpatients services caring?

Good 

### Compassion, dignity and empathy

Treating patients with compassion and dignity, politeness and kindness was the key philosophy of the outpatients department. This was stated in the operational policy and reiterated to us a number of times by the managers and staff. We observed patients being treated with respect by all staff. Patients who were there for follow-up appointments or who had previous experience of attending outpatients approached us to tell us voluntarily that they felt staff were caring and kind. We observed staff saying "Hello" to one patient who was known to them from previous visits. One patient told us "I've been coming here for years; they all seem to know me. You get the odd one who ain't great but they are just all so good to me. Friendly, and they really help me."

When we visited, we left 'tell us about your care' cards in the outpatients reception and waiting areas. Twenty-one cards were completed and overall they made positive comments about staff attitudes, telling us that staff were reassuring, kind, well-mannered and sensitive to their needs.

The service received comments from patients through their own comment cards, which were available in all areas of the department. Comments were reviewed in quarterly governance meetings by outpatients managers along with comments and complaints received via Patient Advice and Liaison Service (PALS). When patients had raised an issue or complaint, the action that had been taken by the service in response was recorded. Two complaints related to the poor attitude of reception staff and in both instances the patient was contacted and the member of staff spoken to. The majority of comments regarding caring attitudes were in praise of individual doctors and staff members.

There was an on-site language advocacy service available for staff to access. Staff we spoke with were aware of which languages were in demand, such as Gujarati, Turkish and Spanish, and how to access other services when they needed them. There was, for instance, written

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documentation about conditions and treatments, and a three-way telephone translation service. Staff who could communicate in sign language were also available within the hospital.

## Supporting patients

We observed patients being asked if they needed help because they appeared lost or in need of assistance. Reception staff were alert to the potential support needs of patients who appeared confused, vulnerable or in need of extra help because of mobility issues, and they would call on a member of the nursing staff to assist patients at reception. When patients had been to the department for a previous appointment and had been identified as in need of extra support, this was flagged up on file with a purple sticker, thereby alerting staff to possible extra support needs.

## Privacy and dignity

All patients were treated privately in consultation rooms. We did not see any examples of privacy and dignity being compromised.

## Are outpatients services responsive to people's needs?

(for example, to feedback?)

Good 

## Meeting people's needs

The Department of Health introduced a target of 18 weeks for the maximum time it should take from a patient being referred by a doctor or GP to the start of their treatment. The trust was recording its performance against this and many other standards to measure its level of performance and service quality. All adult clinics were within this 18-week timeframe with the trust setting its own target of a five-week wait. During our inspection, the average wait for adults was seven weeks.

The trust monitored other measures of performance including follow-up rates, did not attend (DNA) rates, numbers of referrals and numbers of cancelled clinics. The trust was using this data to make improvements. Performance data showed some high rates of cancelled clinics in the middle of 2013 (25) but with an improvement by August 2013 to just one cancelled clinic. This was the most recent data available to us. The trust's own

comparison with national performance indicators showed that the hospital was seeing 1,000 more patients per month than the national average for hospital outpatients departments. Despite this increase in demand, the trust cancelled fewer appointments per month when compared to the national average.

Outpatients ran a partial booking scheme alongside 'choose and book', an NHS electronic referral service that gave patients a choice of date and time for their first outpatient appointment. With the partial booking scheme, patients were written to when a referral was received, and invited to call the bookings team who would book appointments at a time that suited the patient. Generally the feedback from patients about this was very positive. Patients felt the booking process worked for them and being sent text message reminders about their appointments was particularly favoured.

Patients we spoke with were not aware of how long the delay for their appointment was. Staff told us clinics were running on time with slight delays at the time of our visit. A whiteboard system was used to inform patients in different clinics whether there was a delay and how long they would have to wait. The whiteboard system for one clinic said 'no delays' but in fact there was a delay of half an hour. One patient told us they had been asked to come 20 minutes early on every occasion but had always had to wait a further half hour. Another told us that the day of our inspection was the first time they had been informed by staff of the length of the delay.

Nursing staff told us that waiting times was the most common cause of patient dissatisfaction. Patient survey data also showed there were low numbers of patients seen within 15 minutes of their appointment time and high numbers of patients not being told that clinic was delayed or why the clinic was late. The whiteboard system did not appear to be accurate at the time of our visit, although staff told us it had reduced the level of complaints about waiting times. Installation of an electronic messaging system providing live updates on where individual patients were in the queue was planned by the department.

Patients raised issues about the phlebotomy service running with long delays. Waits of two hours were reported as commonplace. In response to this, the outpatients department was taking over the management of the phlebotomy service. To reduce congestion, it was planned to provide extra clinics within the outpatients department

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and to locate a phlebotomy walk-in clinic within the local area. Patients who were disabled or frail told us they were prioritised by the phlebotomy service and did not have to wait the length of time others told us about.

## Vulnerable patients and capacity

Reception staff were alert to the potential support needs of patients who appeared frail, vulnerable or in need of extra help because of mobility issues and, when necessary, they called on a member of the nursing staff to assist a patient from reception. When patients had been to the department for a previous appointment and had been identified as vulnerable or in need of extra support, this was flagged up on their file with a purple sticker, alerting staff to extra support needs.

A purple booklet was provided for patients who found verbal communication difficult. It enabled patients to understand their treatment and communicate their condition through pictures. It contained sections on their basic details, carer's details and how they wished to be treated and cared for.

We also found the service was welcoming and accommodating to relatives and carers, who told us they felt involved in their loved one's care. We found one example when a clinic appointment had been organised so that a close relative could join the consultation from another country via Skype.

## Access to services

There was a transport desk located near the outpatients department where a co-ordinator checked arrivals and booked transport for patients' follow-up appointments. Pick-up and delivery for inward and outward journeys were recorded using an IT system. Patients who were in a wheelchair or frail spoke favourably about the staff and about the service's responsiveness to their needs. They told us that the service prioritised them because of their conditions. We were also told it was reliable and patients were picked up within the half-hour window that had been arranged. The transport co-ordinator demonstrated good rapport with the patients and was aware of those who might need extra support.

## Learning from experiences, concerns and complaints

The staff in the outpatients department placed an emphasis on trying to resolve patients' issues immediately. If this was not possible, the reception manager, charge

nurse or head of outpatients would be called and would try to resolve the issue. If patients were still not happy, they were advised of the Patient Advice and Liaison Service (PALS) service to assist them in making a complaint.

Staff explained the complaints procedure to us. However, this information was not available to patients through leaflets, posters or any other format. We also found that PALS information was not on display anywhere within the department.

The PALS office was located near reception within 'the health shop' but it did not advertise itself at the front of the health shop. If patients did not feel confident about raising an issue there and then or did not want to complain to the service about a member of staff, for instance, it was not clear how they were made aware of the process to follow.

When patients had raised a complaint, we saw that the service had responded and made efforts to resolve the issue to the patient's satisfaction: for instance, by arranging a further appointment with a consultant when a patient was unsure about their care, or addressing an issue between a patient and a member of staff and then writing to the patient to report what action had been taken. Issues and complaints raised and resolved to patients' satisfaction at the time were not documented along with comments and complaints made at a later date.

Handheld devices known as 'Picker' were used by volunteers to ask patients about their experiences. A report had been produced every three months since February 2012. A high percentage of patients (more than 90%) said they had enough time with clinicians, were involved in decision making, thought the department was very clean, and would recommend the department to family and friends. These were all categorised as green on a red/amber/green rating.

However, an average of 65% of patients consistently said they were not given a choice of appointment time. This was given a 'red' rating. The head of outpatients told us they were seeking to clarify this statistic because survey information was limited. They wanted to find out whether, instead of queuing up to book follow-up appointments, patients were placing an appointment request in a pigeonhole, and therefore not being given a choice of time. They also queried whether a patient had received an appointment letter offering them a 'partial appointment'

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but had not understood the booking process from then on. As a response, the service had produced a leaflet explaining the booking process, which was sent out with appointment letters.

The outpatients department had also been ringing patients back after an appointment booked by telephone to ask questions such as the time it took to get through, did call handlers introduce themselves, was their query dealt with and their rating of the service. This led the service to introduce the coaching of call handlers and a standardised way for them to introduce themselves.

## Are outpatients services well-led?

Good 

### Vision, strategy and risks

A trust strategy document set out recommendations for outpatient services, including the implementation of technology to improve the outpatient process: for example, self-check in kiosks and text reminders about appointments. However, it was noted that these solutions had not yet been implemented across the clinics.

### Governance arrangements

A performance review was produced monthly by the medical division to which outpatients belonged. It was presented to the chief operating officer and gave an overall view of performance to the executive team, including the identification of any live issues, where gaps might be and where help was needed.

### Leadership and culture

There were clear lines of accountability and a clear management structure within the outpatients department. Sections such as bookings, records, reception and clinical each had a manager to oversee them. A head of outpatients maintained oversight of all functions and shared an office with the clinical and reception managers; this kept channels of communication open. Monthly and quarterly meetings took place for the outpatients leadership team to monitor and discuss developmental, managerial and risk issues.

An operational policy had recently been implemented that outlined the key functions and tasks of the outpatients department. Central to the ethos and philosophy of the department was to treat patients with respect and dignity, be friendly, polite and courteous. This was clearly stated in the policy. The leadership within outpatients reiterated this to us and it was noticeable during both our announced and unannounced visits to the department. Managers were visible within the department to patients, relatives and staff, and seen to be providing clear leadership. For instance, a clinical shift leader was on duty each day to co-ordinate clinical activities and deal with live issues as they arose throughout the day. We observed them taking care of patient issues within the waiting areas, being asked for advice and supporting staff.

### Patient experiences, staff involvement and engagement

An outpatients board was set up last summer. Its aim was to manage outpatient performance against key performance indicators and take account of feedback from patients and staff. The outpatients department was managed within one medical division of the hospital although clinics came from all three medical divisions, which posed a challenge to concerted leadership. In order to address this and maintain an oversight, permanent membership of the outpatients board included the directors of all three medical divisions as well as the head of outpatients and its clinical lead. It met monthly and core agenda items were patient/staff feedback, environmental issues, monitoring key performance indicators, clinical profiles and implementation of outreach clinics.

### Learning, improvement, innovation and sustainability

In response to meeting waiting time targets, a 'task and finish' group was established with senior representatives from each of the clinical boards to focus on improving performance. An outpatient efficiency group had also been established and tasked to review the scheduling of appointments, increase productivity and improve utilisation of clinics.

This section is primarily information for the provider

## Compliance actions

### Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p><b>Regulation 22 Staffing:</b></p> <p>The trust had not taken appropriate steps to ensure that at all times there are sufficient members of suitably qualified, skilled and experienced staff employed for the purposes of carrying on the regulated activity in medical care.</p>
Treatment of disease, disorder or injury	<p><b>Regulation 20 (1)(a) Records:</b></p> <p>The trust had not ensured that service users are protected against the risks of unsafe or inappropriate care and treatment by means of an accurate record which should include appropriate information and documents in relation to the care and treatment planned and provided to each service user in medical care and recovering from surgery.</p>
Treatment of disease, disorder or injury	<p><b>Regulation 17 (1)(f)</b></p> <p>The trust must make sure service users and their carers are involved in decisions relating to their resuscitation status and this involvement is recorded.</p>