Airedale NHS Foundation Trust

Airedale General Hospital

Quality Report

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

Ratings

Medical care (including older people's care)	Not sufficient evidence to rate
Critical care	Not sufficient evidence to rate

Summary of findings

Letter from the Chief Inspector of Hospitals

The Care Quality Commission (CQC) carried out an unannounced inspection of Airedale General Hospital on the 5 September 2016. The purpose was to look at specific areas in relation to the safe and well-led domains on the Critical Care Unit (CCU) and on some of the medical wards.

The areas inspected in September 2016 included a selection of wards/departments that were identified as a concern during the March 2016 comprehensive inspection, as well as areas where concerns were not identified during the previous inspection but where local intelligence suggested that risks may have increased in those areas. This included concerns regarding risks of patients deteriorating without appropriate monitoring or escalation, and nurse staffing levels.

CQC will not be providing a rating to Airedale General Hospital for this inspection. The reason for not providing a rating was because this was a very focused inspection carried out to assess whether the trust had made significant improvement to services within the prescribed time frame.

In Medical care our key findings were:

- Daily checks of emergency equipment on ward 15 had not been completed daily when patients had been cared for on the ward. The resuscitation trolley had not been checked for the previous six days and there was no oxygen on the trolley. This had been recently replaced and was stored elsewhere on the unit, which meant in an emergency situation staff may not have all the appropriate equipment available for them to use.
- On the ward there was a signposted male toilet area and a disabled toilet and shower cubicle. There was no dedicated female bathroom on the ward on the day of inspection.
- Ward 15 did not store controlled drugs; these were provided by ward 14. Therefore if a patient on ward 15 required controlled drugs the nurse would be given assistance of a registered nurse from ward 14 to check and administer the drug. If ward 14 was busy, the nurse would bleep for the assistance of a matron.
- On the day of inspection we found records were not stored securely on ward 15. Medical and nursing notes were stored in cardboard boxes on the nurses' station, and were left unattended whilst staff cared for patients.
- Monitoring of patients on the ward with telemetry varied dependent on clinical need and the patients National Early Warning Score (NEWS). The ward would undertake their own observations of a patient and record on a NEWS chart; however, staff told us there was no guidance as to how often this would be done other than the nurses clinical judgement. We found there was no set guidance from the trust on what ward monitoring should be undertaken for these patients.
- Staff described NEWS and clinical judgement as factors when escalating concerning patients. All staff we spoke with were able to describe the process they would follow. However we found in six patient records that clinical observations had not always been completed in the specified time-frame.
- Following the inspection the trust informed CQC that ward 10 had opened on one occasion on 29 September 2016. The opening of the additional 4 beds was in response to a surge in acute activity. To ensure the area was staffed safely, the decision was made to open the doors between the wards 9 and 10. Ward 9 staff had cared for the four patients located on ward 10 in addition to the patients on ward 9. This meant there were two registered nurses with support from Health care assistants for a total of 33 patients for the night shift.

In Critical Care our key findings were:

- Staff told us that sharing information and learning from incidents had improved on the unit.
- The unit had closed beds since our inspection in March 2016 to support safer nurse staffing levels. We reviewed staffing data for three months and saw there was a general improvement in nurse staffing levels however there still remained shortfalls on some shifts and the unit did not have a supernumerary co-ordinator.

Summary of findings

- There had been a process of two person equipment checks introduced in critical care following a serious incident in April 2016. Staff were required to check 'high risk' equipment with another nurse at the beginning of each shift or for each new admission. However we observed three care charts and one chart did not have a countersign for one shift out of three opportunities to do so.
- Since our inspection in March 2016 the trust had introduced a new process for the monitoring of telemetry patients and the nurse co-ordinator on the critical care unit had oversight of telemetry patients.
- The unit had developed a process for monitoring staff compliance with medical device training. The ward educator was managing the training and the lead nurse had oversight of this. We saw there was a good level of compliance with the training.
- Changes had been made at a senior leadership level and support had been put into place on the unit. There was now a dedicated lead nurse, matron and nurse consultant working on the unit.
- Staff we spoke with felt that safety had been given greater priority and that incidents and lessons learnt had been shared in an open and transparent way at staff meetings. Staff spoke positively about the new management team.
- There was an improved process and system for appraisal of staff across the unit. The new lead nurse and nurse consultant had achieved 81% of all staff appraisals over three months, with planned dates in place for the remaining team.
- The clinical nurse educator had been given more time to fulfil the expectations of the role and worked alongside staff or released staff to attend training. There was co-ordination of all staff commencing and completing the critical care STEPS training programme in order to evidence competence and knowledge of the team.
- Following our inspection in March 2016 the trust had put in place a critical care action plan. We reviewed the action plan and found that of a total of 23 recommendations, 19 had been delivered, three were on track to be delivered and one was partially delivered.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Medical care (including older people's care)	Not sufficient evidence to rate	We have not rated this key question because this was undertaken as a focused inspection to assess concerns related to patients deteriorating without appropriate monitoring or escalation, the checking of appropriate equipment and nurse staffing levels. Our main findings were: • Daily checks of emergency equipment on ward 15 had not been completed daily when patients had been cared for on the ward. The trolley had not been checked for the previous six days and there was no oxygen on the trolley. This had been recently replaced and was stored elsewhere on the unit, which meant in an emergency situation staff may not have all the appropriate equipment available for them to use. • On the ward there was a signposted male toilet area and a disabled toilet and shower cubicle. There was no dedicated female bathroom on the ward on the day of inspection. • Ward 15 did not store controlled drugs; these were provided by ward 14. Therefore if a patient on ward 15 required controlled drugs the nurse would be given assistance of a registered nurse from ward 14 to check and administer the drug. If ward 14 was busy, the nurse would bleep for the assistance of a matron.On the day of inspection we found records were not stored securely on ward 15. Medical and nursing notes were stored in cardboard boxes on the nurses' station, and were left unattended whilst staff cared for patients.Monitoring of patients on the ward with telemetry varied dependent on clinical need and the patients National Early Warning Score (NEWS). The ward would undertake their own observations of

Summary of findings

a patient and record on a NEWS chart however staff told us there was no guidance as to how often this would be done other than the nurses clinical judgement. We found there was no set guidance from the trust on what ward monitoring should be undertaken for these patients.

- Staff described NEWS and clinical judgement as factors when escalating concerning patients. All staff we spoke with were able to describe the process they would follow. However we found in six patient records that clinical observations had not always been completed in the specified time-frame.
- Following the inspection the trust informed CQC that ward 10 had opened on one occasion on 29 September 2016. The opening of the additional 4 beds was in response to a surge in acute activity. To ensure the area was staffed safely, the decision was made to open the doors between the wards 9 and 10. Ward 9 staff had cared for the four patients located on ward 10 in addition to the patients on ward 9. This meant there were two registered nurses with support from Health care assistants for a total of 33 patients for the night shift.

Critical care — **Not sufficient evidence to rate**

We have not rated this key question because this was undertaken as a focused inspection to assess whether improvements had been made since our comprehensive inspection in March 2016.
Our main findings were:

- Staff told us that sharing information and learning from incidents had improved on the unit.
- The unit had closed beds since our inspection in March 2016 to support safer nurse staffing levels. We reviewed staffing data for three months and saw there was a

Summary of findings

general improvement in nurse staffing levels however there still remained shortfalls on some shifts and the unit did not have a supernumerary co-ordinator.

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- Since our inspection in March 2016 the trust had introduced a new process for the monitoring of telemetry patients and the nurse co-ordinator on the critical care unit had oversight of telemetry patients.
- The unit had developed a process for monitoring staff compliance with medical device training. The ward educator was managing the training and the lead nurse had oversight of this. We saw there was a good level of compliance with the training.
- Changes had been made at a senior leadership level and support had been put into place on the unit. There was now a dedicated lead nurse, matron and nurse consultant working on the unit.
- Staff we spoke with felt that safety had been given greater priority and that incidents and lessons learnt had been shared in an open and transparent way at staff meetings. Staff spoke positively about the new management team.
- There was an improved process and system for appraisal of staff across the unit. The new lead nurse and nurse consultant had achieved 81% of all staff appraisals over three months with planned dates for the remaining team.
- The clinical nurse educator had been given more time to fulfil the expectations of the role and worked alongside staff or released staff to attend training. There was

Summary of findings

coordination of all staff commencing and completing the critical care STEPS training programme in order to evidence competence and knowledge of the team.

- Following our inspection in March 2016 the trust had put in place a critical care action plan. We reviewed the action plan and found a total of 23 recommendations, of these 19 had been delivered, three were on track to be delivered and one was partially delivered.

Airedale General Hospital

Detailed findings

Services we looked at
Medical care (including older people's care); Critical care;

Detailed findings

Contents

Background to Airedale General Hospital

Airedale NHS Foundation Trust provides acute and community services to a population of over 200,000. The trust primarily serves people from a widespread area covering 700 square miles within Yorkshire and Lancashire, including parts of the Yorkshire Dales and the National Park in North Yorkshire, reaching areas of North Bradford and Guiseley in West Yorkshire and extending into Colne and Pendle in the East of Lancashire.

The main hospital site is Airedale General Hospital, which provides a range of acute services. There are also inpatient beds at Castleberg Hospital, near Settle. Community services are provided across the north of the region from sites including Coronation Hospital in Ilkley and Skipton Hospital.

There are approximately 358 beds at the trust including 317 general and acute care, 27 maternity and 14 critical care beds.

The catchment area of Airedale NHS Foundation Trust includes people in Craven and Pendle district councils as well as from Bradford and Leeds unitary authorities (UA). Pendle district and Bradford UA are both in the most deprived quartile of local authorities nationally, Leeds UA is in the second quartile while Craven district is the least deprived and in the fourth quartile nationally.

The trust's main Clinical Commissioning Group is Airedale, Wharfedale and Craven Clinical Commissioning Group.

Our inspection team

Our inspection team was led by:

Inspection Lead: Sarah Dronsfield Inspection Manager

The team included four CQC inspectors and a specialist advisor critical care consultant doctor.

How we carried out this inspection

We undertook an unannounced inspection of Airedale General Hospital on the 5 September 2016. The purpose of the inspection was to follow-up on information of concern the Care Quality Commission had received about the critical care unit and some of the medical wards. These were also some of the key areas of concern which had been identified in March 2016 inspection.

We spoke with a range of staff in the hospital, including nurses, junior doctors, consultants, administrative and clerical staff. We talked with patients and staff from the ward areas. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

Medical care (including older people's care)

Safe	
Overall	**Not sufficient evidence to rate**

Information about the service

Medical care services at Airedale General Hospital were managed in the Integrated Care and Diagnostic Services Directorate. There were 177 inpatient medical beds across nine wards and there were 12,817 medical admissions between December 2014 and November 2015.

We visited the following medical wards; ward 7 (cardiology and respiratory), ward 10 (winter ward - this is a ward that is open to create extra beds during times of increased demand) and ward 15 (extra capacity ward). We also visited ward 13 (gynaecology) as this ward had medical patients being cared for on there.

Summary of findings

We have not rated this key question because this was undertaken as a focused inspection to assess concerns related to patients deteriorating without appropriate monitoring or escalation, the checking of appropriate equipment and nurse staffing levels.

Our main findings were:

- Daily checks of emergency equipment on ward 15 had not been completed daily when patients had been cared for on the ward. The resuscitation trolley had not been checked for the previous six days and there was no oxygen on the trolley. This had been recently replaced and was stored elsewhere on the unit, which meant in an emergency situation staff may not have all the appropriate equipment available to them to use.
- On the ward there was a signposted male toilet area and a disabled toilet and shower cubicle. There was no dedicated female bathroom on the ward on the day of inspection.
- Ward 15 did not store controlled drugs; these were provided by ward 14. Therefore if a patient on ward 15 required controlled drugs the nurse would be given assistance of a registered nurse from ward 14 to check and administer the drug. If ward 14 was busy, the nurse would bleep for the assistance of a matron.
- On the day of inspection we found records were not stored securely on ward 15. Medical and nursing notes were stored in cardboard boxes on the nurses' station, and were left unattended whilst staff cared for patients.
- Monitoring of patients on the ward with telemetry varied dependent on clinical need and the patients National Early Warning Score (NEWS). The ward would undertake their own observations of a patient and record on a NEWS chart however staff told us there was no guidance as to how often this would be

done other than the nurses' clinical judgement. We found there was no set guidance from the trust on what ward monitoring should be undertaken for these patients.

- Staff described NEWS and clinical judgement as factors when escalating concerning patients. All staff we spoke with were able to describe the process they would follow. However we found in six patient records that clinical observations had not always been completed in the specified time-frame.
- Following the inspection the trust informed CQC that ward 10 had opened on one occasion on 29 September 2016. The opening of the additional 4 beds was in response to a surge in acute activity. To ensure the area was staffed safely, the decision was made to open the doors between the wards 9 and 10. Ward 9 staff had cared for the four patients located on ward 10 in addition to the patients on ward 9. This meant there were two registered nurses with support from Health care assistants for a total of 33 patients for the night shift.

Are medical care services safe?

Environment and equipment

- On ward 15 at time of inspection there were 10 patients (both males and females) and there was a further planned admission. There were three bays on the ward along one corridor, each contained four beds.
- On the ward there was a signposted male toilet area and a disabled toilet and shower cubicle. There was no dedicated female bathroom on the ward on the day of inspection.
- We were told female patients used washing facilities on the adjoining ward 14. However, signage on hygiene and toilet facilities were not clear for patients and this raised concerns of mixed sex breaches, whereby male and female patients could access the same facilities at the same time. We raised this with senior managers during the inspection.
- There was a visitor toilet on the exit corridor of the ward; staff told us this was where they directed female patients. During our inspection one female patient told us they needed observation whilst walking to the toilet and they had to shout staff as the buzzer didn't work. During the course of our inspection we witnessed a patient shouting for assistance after using the toilet. This was also raised with senior nursing staff at the time of inspection.
- On review of the checks regarding emergency equipment on ward 15 this highlighted checks had not been completed daily when patients had been cared for on the ward. The resuscitation trolley, according to the recorded checklist, had not been checked for the previous six days. We found there was no oxygen on the trolley. Staff said this had been recently replaced and was stored elsewhere on the unit, which meant in an emergency situation staff may not have all the appropriate equipment available to them to use.
- We raised this with senior nursing staff at the time of inspection who rectified this immediately and a full review of the emergency equipment trolley was undertaken.

Medicines

- We found that ward 15 did not store controlled drugs; these were provided by ward 14. Therefore if a patient on ward 15 required controlled drugs the nurse would be given assistance of a registered nurse from ward 14 to check and administer the drug. If ward 14 was busy, the nurse would bleep for the assistance of a matron. This meant there could be a delay in patients receiving medication they required.

Records

- On the day of inspection we found records were not stored securely on ward 15. Medical and nursing notes were stored in cardboard boxes on the nurses' station, and were left unattended whilst staff cared for patients. Therefore, confidential patient information could be accessed.
- We reviewed five sets of records on ward 15; we found the medical notes had loose sheets containing patient information, which could result in information being lost.
- We found within the nursing records they provided details of the care given and required by the patient. However, we found in some records it was not always clear what part of a care plan had been implemented and not all the appropriate risk assessments had been fully completed. For example, in one record it was not clear if the falls care plan had been implemented.

Assessing and responding to patient risk

- On the day of inspection we found ward 10 the winter ward was closed. The trust were holding a planning day for re-opening of the ward with admission criteria and this was due to take place in the following week. The plan was to re-open the ward with 30 beds.
- Information supplied by the trust following the inspection indicated that ward 10 had been opened on one occasion in September on 29 September 2016. This was on the evening and night of that day and four beds were opened.
- The opening of the additional four beds had been in response to a surge in acute activity. To ensure the area was staffed safely, the decision had been made to open the doors between the wards 9 and 10.
- Ward 15 was used as a surge capacity area which could take a maximum of 12 patients and was opened intermittently. For the month of September 2016 the trust provided information which showed the ward had 218 patients on ward 15 over the month. These figures were based on occupancy at midnight and would include the same patients who had stayed on the ward longer than 24 hours.
- The trust had identified that the patients to be nursed on ward 15 were low risk patients, for example, patients who were due to be discharged in the next 24-48 hours and patients who were low dependency.
- We saw in patient records on the day of inspection there were two patients who had stayed over 48 hours on ward 15.
- We also found there were two patients who were being cared for on the ward who had additional needs in relation to mobility and one patient who required two members of staff to hoist them. This meant there would be occasions where both members of staff on the ward would be caring for one patient and there would be no other staff available to the other patients.
- Monitoring of patients on the ward with telemetry varied dependent on clinical need and the patients National Early Warning Score (NEWS). The ward would undertake their own observations of a patient and record on a NEWS chart however staff told us there was no guidance as to how often this would be done other than the nurses clinical judgement. We found there was no set guidance from the trust on what ward monitoring should be undertaken for these patients.
- Staff described NEWS and clinical judgement as factors when escalating concerning patients. All staff we spoke with were able to describe the process they would follow. However we found in six patient records that clinical observations had not always been completed in the specified time-frame.
- Observation charts were kept by the patient at the bedside along with risk assessments for patients and intentional round documentation.
- There was evidence that staff undertook risk assessments for patients, examples we saw were pressure ulcer risk assessment, falls, nutrition and infection.

Nursing staffing

Medical care (including older people's care)

- We found on wards 7 and 13 the planned and actual staffing figures were displayed and the planned and actual for registered nurses on the day of inspection matched.
- Both Ward 7 and 13 planned nurse staffing levels were based on the ratio of one registered nurse for eight patients.
- We looked at one weeks off duty in the months of June, July and August 2016 on ward 13 to see how often planned and actual staff levels for registered nurses were met. We found that:
  - The week commending 13 June 2016 = a total of two shifts did not meet planned staffing levels.
  - The week commencing 18 July 2016 = a total of three shifts did not meet planned staffing levels.
  - The week commencing 8 Aug 2016 = a total of five shifts did not meet planned staffing levels.
- Staff on ward 13 told us there was more difficulty in covering health care assistant hours. Staff told us of the escalation procedure when there were staff absences.
- Ward 15 was staffed with one registered nurse and one health care assistant to a maximum of 12 patients. By staffing the ward with one registered nurse there were challenges to meeting the needs of patients, for example in providing controlled drugs and meeting the needs of patients when two people were required to provide care.
- The average fill rates for September 2016 on Ward 15 for day and night shifts showed 100%-200% compliance.
- Information supplied by the trust following the inspection indicated that ward 10 had opened on one occasion on 29 September 2016. The opening of the additional 4 beds was in response to a surge in acute activity. To ensure the area was staffed safely, the decision was made to open the doors between the wards 9 and 10. Ward 9 staff had cared for the four patients located on ward 10 in addition to the patients on ward 9. This meant there were a total of 33 patients for the night shift.
- We reviewed staffing levels on ward 9 on the night of 29 September 2016. We saw the ward had:
  - Two registered nurses
  - Four healthcare support workers (HCSW), three of which were agency staff.
- On the morning of 30 September 2016 the four extra patients continued to be supported by a HCSW and also the orthopaedic specialist nurse. At 09:15 a charge nurse from ward 2 was transferred to support the ward with discharging the four patients, all the extra patients were discharged by lunchtime and the four additional beds closed.

Critical care

Safe	
Well-led	
Overall	**Not sufficient evidence to rate**

Information about the service

The Critical Care Unit (CCU) at Airedale hospital has 14 beds and encompasses intensive care, high dependency and coronary care patients. The intensive care unit has three level 3 beds and four level 2 beds. Beds were used flexibly to accommodate the needs of the patients. The unit provides care and treatment of acute and critically ill patients who required cardiac, respiratory, renal and other organ support.

The Acute Care Team (ACT) provides 24 hour support to ward staff following discharge from the critical care unit. ACT is comprised of band 7 nurses with some advanced practice skills, they responded to deteriorating patients on the wards.

Summary of findings

We have not rated the safe or well-led key question because this was undertaken as a focused inspection to assess whether improvements had been made since our comprehensive inspection in March 2016.

Our main findings were:

- Staff told us that sharing information and learning from incidents had improved on the unit.
- The unit had closed beds since our inspection in March 2016 to support safer nurse staffing levels. We reviewed staffing data for three months and saw there was a general improvement in nurse staffing levels; however, there still remained shortfalls on some shifts and the unit did not have a supernumerary co-ordinator.
- There had been a process of two person equipment checks introduced in critical care following a serious incident in April 2016. Staff were required to check 'high risk' equipment with another nurse at the beginning of each shift or for each new admission. However we observed three care charts and one chart did not have a countersign for one shift out of three opportunities.
- Since our inspection in March 2016 the trust had introduced a new process for the monitoring of telemetry patients and the nurse co-ordinator on the critical care unit had oversight of telemetry patients.
- The unit had developed a process for monitoring staff compliance with medical device training. The ward educator was managing the training and the lead nurse had oversight of this. We saw there was a good level of compliance with the training.

Critical care

- Changes had been made at a senior leadership level and support had been put into place on the unit. There was now a dedicated lead nurse, matron and nurse consultant working on the unit.
- Staff we spoke with, felt that safety had been given greater priority and that incidents and lessons learnt had been shared in an open and transparent way at staff meetings. Staff spoke positively about the new management team.
- There was an improved process and system for appraisal of staff across the unit. The new lead nurse and nurse consultant had achieved 81% of all staff appraisals over three months with planned dates for the remaining team.
- The clinical nurse educator had been given more time to fulfil the expectations of the role and worked alongside staff or released staff to attend training. There was co-ordination of all staff commencing and completing the critical care STEPS training programme in order to evidence competence and knowledge of the team.
- Following our inspection in March 2016 the trust had put in place a critical care action plan. We reviewed the action plan and found that of a total of 23 recommendations, 19 had been delivered, three were on track to be delivered and one was partially delivered.

Are critical care services safe?

We have not rated this key question because this was undertaken as a focused inspection to assess whether improvements had been made since our comprehensive inspection in March 2016.

Our main findings were:

- Staff told us that sharing information and learning from incidents had improved on the unit.
- The unit had closed beds since our inspection in March 2016 to support safer nurse staffing levels. We reviewed staffing data for three months and saw there was a general improvement in nurse staffing levels; however, there still remained shortfalls on some shifts and the unit did not have a supernumerary co-ordinator.
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- Since our inspection in March 2016 the trust had introduced a new process for the monitoring of telemetry patients and the nurse co-ordinator on the critical care unit had oversight of telemetry patients.
- The unit had developed a process for monitoring staff compliance with medical device training. The ward educator was managing the training and the lead nurse had oversight of this. We saw there was a good level of compliance with the training.

Incidents

- We reviewed incident data for the critical care unit- ward 16 (CCU). Between 1 June 2016 and 31 August 2016, 47 incidents had been reported, 31 of these resulted in no harm, 12 resulted in low harm and four had yet to be categorised. The most commonly reported incidents related to staffing (10), followed by pressure ulcers developed in hospital (four). Other themes of incident reported included non-clinical out of hour transfers, medication errors and falls.

- Staff we spoke with felt that sharing information and learning from incidents had improved.

Environment and equipment

- At our comprehensive inspection we noted that the unit had 14 beds in total. Not all beds were designated as critical care as there was flexible capacity for low dependency coronary care patients on the unit. In March 2016 the unit had three level three beds (intensive care) and four level two patients (high dependency care) and seven CCU patients could be admitted. The unit had closed beds since our last inspection (four CCU beds, and one level three intensive care bed temporarily).
- During our inspection the unit had eight beds that encompassed intensive care, high dependency and coronary care patients. The intensive care unit had two level three beds and two level two beds, and there were four level one beds for coronary care patients. The number of beds across the unit could be flexed to accommodate the needs of the patient.
- High dependency care patients were now predominantly cared for in an area which also had intensive care patients admitted. Visibility of patients and allocation of nursing staff to patients had improved with these changes.
- The lead nurse said they had completed a business plan to move the four coronary care beds off the unit.
- The unit had telemetry screens to provide remote cardiac rhythm monitoring of patients on medical wards. Up to eight ward patients' telemetry could be monitored on the unit and the co-ordinator on the unit had oversight of this. Following our inspection in March 2016 the unit had purchased five additional telemetry screens to improve the visibility of the screens on the unit. A more robust process was in place for the monitoring of these patients.
- The unit had developed a process for monitoring staff compliance with medical device training. The ward educator was managing the training and the lead nurse had oversight of this. We reviewed the medical devices training matrix and saw 59 pieces of equipment were included. We saw there was a good level of compliance with the training.
- We saw details of the critical care training plan which included training on non-invasive ventilation and continuous positive air pressure (CPAP) hoods, epidural pumps, syringe drivers and tracheostomies.
- There had been a process of two person equipment checks introduced in critical care following a serious incident in April 2016. The process was observed during our inspection. We found that staff were required to check 'high risk' equipment with another nurse at the beginning of each shift or for each new admission. The standard operating procedure (SOP) that we observed was in draft and kept in the staff rota folder so staff could access it easily. The SOP had been ratified and we requested that the latest version was made available to staff. The sign off for the two person check was documented on the critical care chart at the bedside.
- We observed three care charts and one chart did not have a countersign for one shift out of three opportunities. It was clear that the nurses were able to audit the performance of this check easily and snapshot audits had been carried out by the unit manager with compliance at 100%. We discussed the omission with the unit manager and further charts were checked by the team. Work was on-going to provide assurance that the two person process was a preventative measure which was embedded in the unit and staff understood the rationale of this approach.
- We noted that the SOP did not identify if staff would document a two person check in a high risk or emergency situation and the guidance focused on handover processes, rather than in all cases were equipment would be set up for patients.
- We spoke with senior managers regarding the SOP and that it did not detail scenarios such as in an emergency situation. They told us there would be further work to review the SOP.
- A new system had been implemented for medical device training. Every piece of equipment was listed and all members of staff provided evidence of training against each piece of equipment. This system was managed by clinical educator and had oversight from the unit manager and consultant nurse.

Assessing and responding to patient risk

- The unit had telemetry screens to provide cardiac rhythm monitoring for up to eight patients on medical wards.
- We saw that the process for monitoring patients was clearly displayed on the unit alongside an escalation pathway.
- The nurse co-ordinator on the critical care unit had oversight of telemetry patients. Staff had awareness of the new process and lessons learnt from incidents.
- A patient monitoring sheet was completed for all patients on telemetry. Staff completed these during each shift or as an event was observed.
- Ward staff carried bleeps so that they could be contacted promptly and in a timely manner if the staff on the unit were concerned about a patient's cardiac rhythm on telemetry. We saw that the process for monitoring patients was clearly displayed on the unit alongside an escalation pathway.
- Staff we spoke with on the unit were aware of the new process and staff said if a rhythm was recognised as life-threatening; the co-ordinator would contact the medical emergency 'crash' team through the hospital switchboard.
- Following the implementation of the new system the unit completed monthly audits on telemetry effectiveness and knowledge. The audit involved asking staff to respond to five questions to assess their knowledge and the effectiveness of the recent changes made to telemetry monitoring within the critical care unit. Staff were asked the following questions:
  - Do you know there are extra telemetry monitors in place?
  - Can you identify where they are located?
  - Have they enabled you to monitor telemetry patients away from the nurses' station?
  - Do you recognise the alarm sound when an abnormal rhythm occurs?
  - Have the remote monitors enable you to respond more speedily to an abnormal rhythm?
- The audit was conducted in June and July 2016. From the 15 staff asked, ten knew there were extra telemetry monitors and could identify where they were located. 12 staff members said they were able to monitor telemetry patients away from the nurses' station and 14 staff member could recognise the alarm sound when there was an abnormal rhythm. However, nine members of staff felt the remote monitors did not enable staff to respond more speedily to an abnormal rhythm.

Nursing staffing

- The unit had a plan for environmental and staffing capacity for a maximum of three level three patients, four level two patients and four coronary care patients. This was a total of 11 patients. However; at the time of our inspection, one level three bed was closed to support the staffing levels.
- Staff we spoke with told us when the unit was at maximum capacity, three trained staff were required each shift to provide 1:1 ratio care to three intensive care patients. Two trained registered nurses were required each shift to provide 1:2 ratio care for four high dependency patients. One trained nurse was required to care for up to four coronary care patients. Therefore the unit should have six registered nurses on duty and a supernumerary co-ordinator; on the day of our inspection we found the unit did not have a supernumerary nurse co-ordinator.
- The unit had a newly appointed lead nurse and nurse consultant who were supernumerary.
- On the day of our inspection there were five trained registered nurses on duty for two level 3 patients, four level 2 patients and three coronary care patients with one admission en-route. This was the correct staffing levels for the acuity of the patients however; the senior nurse was co-ordinating the unit, monitoring the telemetry for seven patients on acute medical wards, and caring for three coronary care patients.
- On the day of the inspection the ward clerk was absent and there was no cover available to cover that role, so the nurse co-ordinator was also covering elements of the ward clerk role.
- We reviewed three months of staffing rotas. In June 2016 the actual number of registered nurses was below the planned number on 10 day shifts and eight night shifts.

On one day shift we saw the actual number of healthcare assistants was above the planned level to mitigate the risk. There were 10 days when the actual number of care staff was below the planned level.

- In July 2016 the actual number of registered nurses was below the planned number on 23 day shifts and 17 night shifts. On 12 day shifts the actual number of healthcare assistants was also below the planned staffing level.
- In August 2016 the actual number of registered nurses was below the planned number on one day shifts and four night shifts. There were nine days when the actual number of care staff was below the planned level.
- The unit had a 0.5 whole time equivalent (WTE) clinical educator. The clinical nurse educator had been given more time to fulfil the expectations of the role and worked alongside staff or released staff to attend training.
- The unit had 12 staff out of 42 not available for duty at the time of inspection; this continued to be a challenge for covering the unit rota. Staff we spoke with, told us that staffing had improved recently and were aware of plans that would cover the shortfalls over forthcoming months.
- A staffing review had taken place and elements of this process were on-going. The unit had an interim lead nurse and leadership support from a nurse consultant.
- Skill mix of nurses on night shift was under review to improve opportunities to appoint a greater number of junior nursing staff, which, staff reported, would improve achievement of critical care staffing standards and cover of the patient dependency in the unit.
- A housekeeper role was being implemented on the unit to support patients and allow opportunity for nursing staff to focus on patient care without being called away from the bedside.

Medical staffing

- Staff we spoke with told us that the Consultant led multidisciplinary ward rounds had improved Monday to Friday, however there were on-going plans to improve weekend cover. A formal system of medical and nursing handover was described by staff and took place on a morning and on an evening. We observed the documentation on the critical care chart and care plan that daily review and plans were in place.

Are critical care services well-led?

We have not rated this key question because this was undertaken as a focused inspection to assess whether improvements had been made since our comprehensive inspection in March 2016.

Our main findings were:

- Changes had been made at a senior leadership level and support had been put into place on the unit. There was now a dedicated lead nurse, matron and nurse consultant working on the unit.
- Staff we spoke with felt that safety had been given greater priority and that incidents and lessons learnt had been shared in an open and transparent way at staff meetings. Staff spoke positively about the new management team.
- There was an improved process and system for appraisal of staff across the unit. The new lead nurse and nurse consultant had achieved 81% of all staff appraisals over three months with planned dates for the remaining team.
- The clinical nurse educator had been given more time to fulfil the expectations of the role and worked alongside staff or released staff to attend training. There was co-ordination of all staff commencing and completing the critical care STEPS training programme in order to evidence competence and knowledge of the team.
- Following our inspection in March 2016 the trust had put in place a critical care action plan. We reviewed the action plan and found a total of 23 recommendations, of these 19 had been delivered, three were on track to be delivered and one was partially delivered.

Governance, risk management and quality measurement.

Critical care

- Following our inspection in March 2016 the trust had put in place a critical care action plan. We reviewed the action plan and found a total of 23 recommendations, of these 19 had been delivered, three were on track to be delivered and one was partially delivered.
- Following a serious incident in April 2016 the trust provided information on their initial actions following the incident. One of the actions taken was for staff to complete a two person check when a patient was placed on ventilator equipment.
- The unit had introduced a process for the two person equipment check to be undertaken. We found that staff were required to check 'high risk' equipment with another nurse at the beginning of each shift or for each new admission. The sign off for the two person check was documented on the critical care observation chart at the bedside.
- We reviewed three charts and found one did not have a countersign for one shift. Staff we spoke with were aware of the two person check and were able to describe the process. The lead nurse had completed a snapshot audit of the two person check to provide assurance regarding equipment checks. We reviewed these audit results and saw 100% compliance had been achieved.
- We reviewed the standard operating procedure (SOP) and noted it was in draft and kept in the staff rota folder for staff to get easy access to. However the SOP had been ratified and we requested that the latest version was made available to staff.
- We noted that the SOP did not identify if staff would document a two person check in a high risk or emergency situation and the guidance focused on handover processes, rather than in all cases where equipment might be set up for patients.
- We spoke with the lead nurse who agreed that further work would be done to develop the SOP to provide a clear process for when patient were place on ventilator equipment.

Leadership of service

- Changes had been made at a senior leadership level and support had been put into place to achieve the action plan. There was now a dedicated lead nurse , matron and nurse consultant working on the unit.
- Staff we spoke with felt that safety had been given greater priority and that incidents and lessons learnt had been shared in an open and transparent way at staff meetings. Staff spoke positively about the new management team.
- It was very evident through our discussions that the new unit manager and nurse consultant were monitoring progress and developing improvements where required.
- We observed an improved process and system for appraisal of staff across the unit. Junior staff we spoke with told us that they had been given a recent appraisal. The new lead nurse and nurse consultant had achieved 81% of all staff appraisals over three months with planned dates for the remaining team.
- The senior team had identified six nursing staff to attend the post registration critical care course in 2016 and early 2017 and were committed to achieving the best practice Guidelines for the Provision of Intensive Care Services (GPICS) standards of 50% of staff to have the course.
- The unit had 12 staff out of 42 not available for duty at the time of inspection which continued to be a challenge for covering the unit rota. Staff we spoke with told us that staffing had improved recently and were aware of plans that would cover the shortfalls over forthcoming months.
- The clinical nurse educator had been given more time to fulfil the expectations of the role and worked alongside staff or released staff to attend training. There was co-ordination of all staff commencing and completing the critical care STEPS training programme in order to evidence competence and knowledge of the team. We saw information which indicated that all staff at all levels of experience had commenced the programme at level one and were expected to achieve level three. There was commitment to achieve this plan from senior staff.
- We noted that staff meetings had improved and staff we spoke with felt that sharing information and learning from incidents had improved and was continuing to do so. There was greater confidence in the new line management team amongst staff we spoke with. It was very evident that the new unit manager and nurse consultant were providing monitoring of progress and developing required improvements.