North Somerset Community Partnership Community Interest Company

1-293935970

Urgent care services

Quality Report

Castlewood, PO Box 237,
Tickenham Road
Clevedon,
North Somerset
BS21 6FW
Tel:01275 546800
Website: www.nscphealth.co.uk

Date of inspection visit: 29,30 November 2016
Date of publication: 31/03/2017

Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-310911397	Clevedon Community Hospital	Urgent care services	

This report describes our judgement of the quality of care provided within this core service by North Somerset Community Partnership Community Interest Company . Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by North Somerset Community Partnership Community Interest Company and these are brought together to inform our overall judgement of North Somerset Community Partnership Community Interest Company

Summary of findings

Ratings

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

Contents

Summary of findings

Overall summary

Overall rating for this core service

GOOD

We have rated the minor injury service (MIU) as good overall because:

- People were protected from avoidable harm. There were systems in place to report concerns or incidents and learn from them.
- There were reliable systems, practices and processes in place to keep adults and children safe and safeguard them from abuse, which were embedded in practice.
- The MIU was clean and well equipped and equipment was maintained and fit for purpose.
- Risks to people who used minor injury service were assessed, monitored and managed on a daily basis and incorporated relevant and current evidence based practice guidance and standards.
- New procedures or treatments were researched and reviewed by the relevant clinical governance forum (which oversaw the minor injury service) prior to being implemented in MIU.
- Training was provided for all staff to ensure they were competent and effective in their roles.
- Competency frameworks, peer review and clinical supervision arrangements were robust and ensured Emergency Nurse Practitioners and support staff were fit to practice on an ongoing basis.
- We received positive feedback about the staff and the minor injury service from all the patients we spoke with. Patients told us they were treated with kindness and respect and were always kept informed about their treatment and care.
- People told us they had timely access to the minor injury service and said waiting times were considerably less than attending the emergency department in nearby acute hospitals.
- Practitioners worked collaboratively with multidisciplinary teams across community services and had strong links with specialist services in local acute hospitals.
- Clinical leaders were respected by staff and they were knowledgeable about quality issues and understood the priorities of the minor injury service.
- There was a strong sense of team working in MIU and there were shared values to ensure the delivery of high quality patient care.
- The MIU had developed an innovative approach to the management of pain in children.

Summary of findings

Background to the service

Clevedon Community Hospital minor injury Unit (MIU) provides a walk in service in a purpose built centre for patients with minor injuries such as minor cuts and wounds, minor burns and scalds, strains and sprains and simple fractures. The service is open 365 days of the year from 8am with the last walk in-patient being accepted at 8.30pm to allow closure at 9pm. Patients who present with serious illnesses or injuries are stabilised where appropriate and then transferred to the nearest and most appropriate acute hospital. The minor injuries unit saw 12,038 patients from April 2015 to March 2016. Of which 8,313 were adults and 3,693 were children (aged 17 and under).

Emergency Nurse Practitioners (ENPs) led the unit. ENPs are nurses specially trained who are able to assess, treat and discharge patients.

An onsite plain X-ray facility provided by a third party health care provider was open between 9am and 1pm and 2pm to 5pm on weekdays only. Diagnosis and screening from plain X-rays were undertaken by ENPs in MIU.

We carried out the announced period of our inspection over two weekdays. We observed care and treatment and looked at records of care. We spoke with ten staff, including ENPs, support staff, administrative staff and five patients. We looked at five care records and reviewed information relating to performance about the MIU prior to and following our inspection. We also received feedback via comment cards from patients and the MIU patient satisfaction survey.

Our inspection team

Our inspection team was led by:

Chair: Graham Nice, Managing Director, independent healthcare management consultancy

Team Leader: Tracey Halladay, Care Quality Commission

The team included CQC inspectors and a variety of specialists: a health visitor, emergency nurse, pharmacist, community nurse and palliative care nurse.

Why we carried out this inspection

We inspected this core service as part of our comprehensive community health services inspection programme.

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 29, 30 November and 1, 2 December 2016. During and before the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists. We talked with people who use services. We observed how people were being cared

Summary of findings

for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

What people who use the provider say

- We reviewed feedback from patients who had used the minor injury service between August and October 2016, and 12 comment cards completed by patients during our inspection.
- All the comments received gave positive feedback and talked about 'a caring and responsive minor injury service that was meeting the needs of the local population'. For example, "I was treated with dignity and respect, it was clean and safe and the staff were very caring" and "Excellent service, my child was seen immediately and his injury was discussed with him so I knew his injury was being taken seriously" and "Thank you very much to the nurses, a very prompt, kind, and understanding service".

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- Review the labelling of medicines supplied to patients by the MIU as ready labelled packs to ensure that the labelling complies with the Human Medicines Regulations 2012.
- Develop the governance arrangements for medicines in MIU.
- Consider how to capture data on patient attendance and those patients who leave without being seen.

North Somerset Community Partnership Community Interest Company

Urgent care services

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated services as good for safety because:

- Openness and transparency about safety were encouraged and staff understood and fulfilled their responsibilities to raise concerns and report incidents.
- Safety performance was monitored and reported to locality managers and shared with staff at team meetings.
- Safeguarding adults and children was embedded in practice and there were robust monitoring systems and processes in place.
- The minor injury unit (MIU) was visibly clean, well equipped and well maintained and infection control measures had been implemented.
- Risks to people who used the centre were assessed, monitored and managed on a daily basis.These included signs of deteriorating health, medical emergencies or risks to mental health.
- There was sufficient staff to treat and care for patients that attended MIU.

However,

- The clinical patient information system was not used to provide reports on all the data in the MIU to monitor time from arrival to triage.

Safety performance

- Safety performance for the minor injury service (MIU) included waiting times for assessment and treatment, adverse incidents, complaints and compliments, which were monitored continuously and were reported to the locality manager who had responsibility for the service. This was shared with staff at governance, locality and team meetings. We reviewed safety data from August 2015 to July 2016 and found no serious issues which demonstrated that safety performance over time, based on external and internal information was good.

Incident reporting, learning and improvement

- There were appropriate systems in in place to ensure incidents were reported and investigated properly. Incidents and accidents were reported using an organisation wide electronic system.All staff had access

to this and knew how to use it. Emergency Nurse Practitioners (ENPs) and support staff told us they received feedback after reporting an incident. Clinical leaders in MIU reviewed all incidents weekly.

- All staff we spoke with were aware of their responsibilities in reporting incidents and said they were encouraged to do so.Staff said there was a 'no blame' culture surrounding incidents and they were encouraged to view them as a learning opportunity.
- Learning from incidents was discussed and recorded at locality and governance meetings with information being shared with staff at team meetings. For example, learning from an incident concerning a patient who had tested positive to a bacterial infection which had not been recorded on the patient documentation system or in the patients discharge letter.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation, which was introduced in November 2014. This Regulation requires the organisation to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds.
- Staff we spoke to had a clear understanding of this regulation and told us they had attended a training session on Duty of Candour and knew that if a patient was harmed they were required to be open and honest about what had happened.

Safeguarding

- Staff that we spoke with were familiar with processes for the identification and management of adults and children at risk of abuse. Staff were aware of the safeguarding policies and knew how to access them on the organisations intranet.
- Records showed all ENPs had attended a two-day interagency level three child safeguarding training, which was updated every two years, and also completed level one and level two training on child sexual exploitation. Health care assistants had completed safeguarding training for adults and children at levels one, two and three.
- The clinical patient information system prompted staff to ask about safeguarding when completing a child's assessment. Monthly paediatric notes audits showed compliance throughout 2016 was 100%.
- Demographics were checked against national records (the NHS Spine). All new children (0-18 years) were checked for safeguarding alerts and significant past attendances especially those within the last 12 months and we saw evidence of this in the records maintained by MIU.
- Clinical notes of children attending MIU were faxed to child services for information sharing with the child's GP, health visitor or school nurse. Children outside North Somerset had their notes faxed to their GP from MIU once details of the GP surgery were confirmed and a secure fax number obtained.In the event of a safeguarding concern for an out of area child, the organisations safeguarding protocols were followed.
- All children who left the MIU before being seen had the reason (if known) documented in their clinical notes and we saw examples of where this had been documented.The ENP made every effort to contact the child and the adult with parental responsibilities to discuss the injury, the reason for leaving and offer any further advice or signposting to another service as required. Child services were advised of all children who left before being seen via a secure fax, and if appropriate, the ENP would advise other agencies (social care or the police) in line with the organisations safeguarding children policy.
- Children presenting at MIU were asked about previous attendances in the last 12 months to other healthcare settings and findings were recorded on the safeguarding template.Children frequently attending MIU were flagged to other child services using the appropriate form with details of dates and the presenting problems.
- ENPs were trained in the organisations 'Think family principles' and were required to consider the adult behaviours and interactions when a child presents, especially where drug and alcohol use, domestic abuse or mental health concerns were identified.

Medicines

- The supply of medicines was provided to MIU by a local community pharmacy. The organisation provided

clinical pharmacy services and medicines governance support to MIU. Audits were carried out on controlled drugs and medicines storage. A pharmacist who reviewed the audits and medicine incidents provided further support.

- FP10 prescription forms were stored securely but the recording of FP10 forms (used) was not robust. This was raised at the time of the inspection and a recording form was put in place.
- There was an open culture for reporting medicines incidents, these were investigated and reported on and the learning was shared in team meetings.
- Medicines were stored safely in MIU. Liquid medicines did not have a date of opening (which was not in accordance with the medicines policy). The clinical room temperature was recorded and added to the daily monitoring sheet.
- During the inspection, it was identified that the organisation needed to review the systems for ordering controlled drugs within MIU to ensure that it meets Home Office legislation (Misuse of Drugs Act 1971 and its associated regulations). All orders for controlled drugs in MIU were signed by a non-medical prescriber (NMP) and put into stock. On the last day of the inspection the organisation reviewed the current system and a process was put into place to quarantine the controlled drugs, which had been obtained in this way. Arrangements were put in place to obtain a supply of controlled drugs using a doctor's signature and the organisation was seeking advice from Home Office. The organisation was working with the Home Office to develop further guidance on this.
- The MIU were supplied with pre packed medication by an independent pharmacy. However these did not state the name and address of service the provider. This was raised during the inspection and MIU produced their own address labels to add to pre-labelled packs as an interim measure.

Environment and equipment

- The minor injury service was delivered from a purpose built unit in the community hospital, which was opened in 2013.There were four clinic rooms and a triage (assessment) facility. The design of MIU ensured good visibility of the waiting area, which ensured patients were always observed.The fabric of the building was well maintained.
- There was no separate waiting area or designated treatment rooms for children, although there was a designated clinical children's assessment room.
- Although the waiting area appeared to be adequate, it was cramped at busy times when patients were waiting for X-rays via the GP walk in service as well as patients waiting to be seen in the MIU.
- The MIU was well equipped and equipment was checked daily to ensure it was ready for use.We saw maintenance records and equipment inventories, which showed a regular programme of maintenance and servicing.
- There was a comprehensive range of resuscitation equipment for both children and adults. This was stored in two tamper evident resuscitation trolleys, which were checked daily in accordance with the organisations policy.However, we noted the seals on the soft face masks (used in the resuscitation of adults and children) had deflated and there was no use by date on the packaging.We brought this to the attention of the clinical leads who took immediate action to replace the masks.

Quality of records

- There were no paper records in the minor injury service. All episodes of clinical care were recorded on the electronic patient record system used by community services and in accordance with the organisations standards for documentation. The system was password protected to appropriate staff access.
- Risk assessments were an integral part of the system. For example, allergies and mental health assessments. We looked at five patient records, found that risk assessments had been completed, and were appropriate. All patient records were clear, clinically robust and comprehensive.
- Access to the system was controlled by individual passwords and was locked when the computer was unattended

Good

Are services safe?

Cleanliness, infection control and hygiene

- The minor injury unit, including the waiting room appeared visibly clean, tidy and dust free. Equipment that had been cleaned was identifiable by the use of 'I am clean stickers'.
- Hand disinfectant gel facilities were available in reception and before entering clinical areas. They were clearly signposted to be used prior to entering the department. Hand washing facilities were readily available and we observed staff washing their hands or using disinfectant gel immediately before and after patient contact, which was in line with the National Institute of Clinical Excellence (NICE) Quality Standard 61 (statement 3).
- Hand hygiene audits took place and monthly and consistently showed compliance between 98% and 100%.The "bare below the elbow" policy was adhered to.Staff used aprons and gloves correctly to prevent the spread of infections.
- Cleaning schedules were displayed in clinical and public areas, which was in line with best practice. An infection control (IC) link nurse role was being undertaken by an ENP. Cleaning audits reported compliance above 95% for the last 12 months.

Mandatory training

- There was a wide range of topics included in mandatory training.For example, infection control, basic life support (BLS) frailty, pain awareness, safeguarding and fire awareness. Some topics were covered by e learning and others took place during mandatory training sessions and tailored to the specific needs of the service.
- At the time of our inspection,100% of staff working in the minor injuries service had completed mandatory training in the last 12 months

Assessing and responding to patient risk

- People attending the minor injury service were greeted by a receptionist or a member of staff who had received training in recognising 'red flag' conditions such as chest pain. This initial face-to-face observation provided an immediate assessment. If a person presented with a life threatening condition or the member of staff greeting them had any concerns then the person was taken immediately to the clinical area for a full assessment by the ENP.
- The aim of the minor injury service was to treat minor injuries but the clinical leads had recognised that people would sometimes attend with serious clinical conditions. Therefore, staff had received specific training in the recognition of a deteriorating patient. There were clinical protocols for the recognition of a sick adult, sick child, and life threatening conditions such as peri-arrest situations and sepsis. ENPs and support staff had been involved in the recent project on the management of sepsis.
- Patients who were seriously ill or injured, including children under 12 months, were transferred by ambulance to the emergency department at the nearest acute hospital. Service level agreements (SLA) were in place with local NHS hospitals.
- All children presenting with a minor injury were initially observed on arrival by an ENP and triaged (assessed) within 15 minutes of arrival; those presenting with moderate to severe pain received analgesia within 20 minutes. If the wait to be seen by the ENP exceeded one hour then discretion was used to see children as a priority over adults and was dependent on clinical need.
- Patients had their minor injury/illness assessed, examined, investigated and treated or referred on to a specialist service by an ENP who was trained and qualified to treat adults and children. The national early score system (NEWS) was used to identify patients whose condition was at risk of deteriorating.Points were allocated to a patient's vital signs such as heart rate, temperature and blood pressure to achieve a total score to determine priorities for further action. There was a similar system (PEWS) in place for children. ENPs were able to request and interpret X-rays, independently prescribe or supply medicines under Patient Group Direction (PGD) and provide advanced life support skills in the event of an emergency. ENPs and support staff were trained in Immediate Life Support (PILS), and Paediatric Immediate Life Support (PILS) in line with the standard of the unwell child.
- There was no consistency regarding how quickly an initial patient assessment should be carried out.We

Good

Are services safe?

spoke to three ENPs who told us different times for undertaking triage for "when the waiting times got too long". We were told triage could commence after 15, 30 or 60 minutes.However, the waiting time to see a practitioner appeared better than they actually were. This was because the clinical patient information system did not record if triage had taken place or when it had taken place.

Staffing levels and caseload

- Staffing levels were adequate and filled to establishment to ensure patients received safe care and treatment. The minor injury service was staffed by a minimum of two ENPs and one support worker every day from 8am to 9pm including bank holidays. A support worker trained in the 'red flag' system provided receptionist cover from 9am to 5pm weekdays and from 5pm to 9pm.
- The minor injury service had its own bank of ENPs to cover vacancies and staff sickness. Bank ENPs were trained in line with the MIUs scope of practice for ENPs and the majority of bank staff had undertaken substantive posts in the unit prior to joining the bank. There had been no agency staff used in MIU in the last 12 months. There were no lone workers in the MIU.
- The level of staff sickness and turnover were minimal and staff covered each other's shifts at short notice to ensure continuity of care.

Managing anticipated risks

- There were plans in place to deal with possible disruptions to services such as computer failure, power cuts and flood.
- The MIU was part of the organisations response to major incidents and staff were aware of their responsibilities.
- There were emergency call bells throughout MIU should staff need to summon assistance. Staff had been trained in conflict resolution and felt confident in diffusing aggressive situations. Should there be a risk of violence towards patients or staff the police would be called.

Good

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

We rated effectiveness as good because;

- Emergency nurse's practitioners (ENPs) and support staff were well qualified and demonstrated the skills that were required to carry out their roles effectively and according to best practice.
- There was a clear scope of practice in place for ENPs working in the minor injury service.
- Induction programmes, competency assessment, peer review and additional clinical training, ensured ENPs had the right qualifications, skills, knowledge, and experience to do their job and take on new responsibilities on a continual basis.
- Patient clinical outcomes were monitored regularly and robustly.
- Formal arrangements were in place to enable staff to obtain medical advice.
- There was good evidence of multidisciplinary working between staff in the minor injury service (MIU), the hospital and community services.
- Staff had a good understanding of consent and the mental capacity act.

However,

- The computer system in the minor injury service was unable to record the number of adult patients who left the unit without being seen and the number of unplanned re-attendances within seven days.

Evidence based care and treatment

- MIU used treatment guidelines based on guidance from the National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM).For example, development of head injury advice and guidance, management of sepsis and use of patient group directives (PGDs for adults and children).Management of burns and meningitis protocols were clearly displayed in MIU.
- To ensure continuity of care, patients were referred back to their registerd GP once their urgent care need had been met. Patients who did not have a registered GP or who may struggle to access them were able to access the minor injury service.
- Written information was given to patients (regarding their conditions and treatment) and was consistent and in-line with the relevant guidance. For example, management of simple fractures.
- Policies, procedures and guidelines were available to staff on the organisations intranet.Staff we spoke to knew how to access them when necessary.
- Documents and policies had been developed in line with guidance from a range of sources, for example: the statement of CQCs roles and responsibilities for safeguarding adults and children (JUNE 2015).
- Monthly audits helped to ensure guidance was being followed. Audit results showed good compliance for example medicines audits and patient notes documentation reviews.
- ENPs were able to request and interpret X-rays, independently prescribe or supply medicines under Patient Group Directives (PGDs) and provide advanced life support skills in the event of an emergency.

Pain relief

- Patient's records showed a pain score was always calculated and recorded using a recognised pain tool.Pain relief was given and the effects were monitored.
- During our inspection, we observed timely pain relief administered to children.This was in line with the standard operating procedure (SOP) for the minor injury service. All children with a minor injury were required to be initially observed on arrival by an ENP and triaged (assessed) by an ENP within 20 minutes of arrival. Children presenting with moderate to severe pain received analgesia within twenty minutes. The results of pain relief were monitored and additional treatment given if necessary.

Good

Are services effective?

Nutrition and hydration

- 95% of patients spent less than 50 minutes in the MIU and so food was not provided.A café was onsite if patients required snacks and hot and cold drinks.People we spoke to told us the café was easy to find and of a good quality.

Patient outcomes

- The clinical leads and ENPs undertook real-time peer review of the effectiveness of care and treatment throughout our inspection. We observed a number of discussions between staff regarding diagnosis and treatment.If further advice were required, the clinical lead would contact nearby hospitals to provide advice and guidance from specialists in emergency care. This was a formal arrangement and was supported by standard operating procedure (SOP) which staff knew how to access.
- A low rate or unplanned re-attendances within seven days are often used as an indicator of good patient outcomes.The clinical patient information system did not record unplanned re-attendances.The national average for urgent and emergency care is 7.5%. This meant the organisation was unaware of the rate of unplanned re-attendances within seven days.However, the clinical leads believed this was a low percentage in the minor injury service.
- The minor injury service was not recording the number of adult patients who left the unit without being seen, as the patient information system did not record this data. However, the minor injury service had put in place robust systems to contact children who left the service without being seen.
- Monthly audits of compliance with clinical protocols, medicines management and the number of missed fractures were undertaken. For example, in the reporting period November 2015 to October 2016, 2,732 X-rays were undertaken in the MIU and interpreted by the ENPs. There were 26 (0.9%) missed fractures for adults and 12 (0.4%) for children. Whilst there is little benchmarking data on urgent care service performance, the percentage of missed fractures for adults and children in the MIU appeared to be low.

Competent staff

- The ENP role in the minor injury service utilises the skills and experiences of senior nurses with an emergency care background and encourages the development of extended skills, knowledge, expertise and diagnostic reasoning in order to provide evidence based, high quality, effective and safe care for patients. ENPs and support staff were experienced and fully trained in the assessment and treatment of adults and paediatric minor injuries. Patients attending the minor injury service could expect to have their injury/illness assessed, diagnosed and treated or referred for specialist opinion, by a competent ENP in a timely manner.
- ENPs and support workers in MIU at the start of their employment and on returning after a significant period of absence (maternity leave and sick leave) participated in a structured orientation programme. All MIU staff completed the mandatory training requirements of the organisation.
- ENPs undertook their role in MIU in line with a scope of practice. This required ENPs to utilise their skills and experiences as senior nurses with an urgent or emergency care background who had extended skills, knowledge and expertise in autonomous practice. This included the use of clinical and safe care for patients.
- All ENPs had undertaken a recognised course in autonomous practice, followed by a six-month preceptorship programme to consolidate their learning post completion of the course. During the consolidation period, ENPs did not discharge patients independently but discussed patients with a mentoring ENP in the unit.
- ENPs were also required to undertake additional clinical skills training. For example, IR(M)ER certificate for the safe requesting of radiological investigations and paediatric/adult interpretation of radiology (X-ray) (SEXI-Paeds SEXI), non-medical prescriber or the ability to supply medication using patient group directions (PGDs) and immediate life support (ILS) for adults, and PILS for paediatrics.
- Each ENP held their own practice log and were able to evidence their own practice. Any expansions to practice,

for example, learning new skills under supervision, required research and investigation prior to discussion with the clinical lead and locality manager before implementation.

- All health care assistants had a Level 3 vocational qualification and were responsible for maintaining their personal competency in the use of medical devices in MIU.
- A framework of staff appraisal and clinical supervision was in place and 100% of staff had undertaken appraisal in the last 12 months.
- The clinical leads had identified the need to have formal clinical supervision providedby an emergency department consultant from an acute hospital.This was entered onto the organisations risk register in October 2016 and forwarded to the clinical council for review.

Multi-disciplinary working and coordinated care pathways

- There were good working relationships with other teams at the hospital and with the wider healthcare community. Robust links had been established with other health service providers and voluntary sector organisations through integrated clinical networks and care pathways.
- If patients needed urgent hospital treatment they were directly referred to specialist doctors such as orthopaedic surgeons, burns specialists, rheumatologists and dermatologists in the nearest acute hospital in line with service level agreements (SLAs). A referral letter was sent with the patient in order to confirm information discussed with the specialist at the time of referral.
- Patient referrals from other health care providers and private agencies were received by the minor injury service and organisations were advised that a telephone call prior to a patient's attendance was a helpful but not essential requirement.
- Referrals from the designated ambulance provider were welcomed by the service but were required to be in line with the agreed clinical criteria and the established care pathway.

Referral, transfer, discharge and transition

- Letters were sent electronically to GPs after each attendance.Practitioners told us that, if people were likely to have difficulty making follow-up appointments with their own GP (for example, those with communication difficulties or dementia), staff would make an appointment on their behalf before they left the unit.

Access to information

- The minor injuries unit used the same computer system as many local GPs.This meant that staff had access to patients' previous medical history and medication records so discharge summaries could be sent electronically.The patient record system recorded basic demographic information and contained clinical templates that helped practitioners to collect all the information needed to achieve an accurate diagnosis.
- Previous X-rays and their results were always available via the computer.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- We observed that verbal consent was obtained for any procedures undertaken by staff.
- Consent forms were available for people with parental responsibility to consent on behalf of children. The ENPs we spoke with had a good working knowledge of the guidance for gaining valid informed consent from a child. They were aware of the legal guidelines, which meant that children under 16 were able to give their own consent if they demonstrated sufficient maturity and intelligence to do so (known as Gillick competencies). Otherwise, consent would be sought from the child's parent or guardian. If a child attended without a person who was able to provide consent, staff would attempt to contact an appropriate adult.
- ENPs we spoke with were aware of issues surround consent and mental capacity and had received training in the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.
- Staff were able to complete mental health assessments using the diagnostic tool on the clinical computer record and was able to refer patients to appropriate mental health services. For example, psychiatric liaison

Good

Are services effective?

services in the emergency department in the nearest acute hospital if urgent assessment was required or to make an appointment with the patients GP if less urgent intervention was required.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary

We rated caring as good because:

- Feedback from patients and relatives confirmed that staff were caring and kind.
- People were kept informed and given information about their condition and their care and treatment.
- Patients received care from nurses and support staff that treated them with dignity and respect in the minor injury unit (MIU) and they were always listened to and felt able to raise concerns.
- ENPs were skilled in communicating with patients and were able to quickly build relationships with them.
- 98.3% of patients in between July and September 2016 said they would recommend the MIU service to others.

Compassionate care

- The receptionist in the minor injury unit (MIU) greeted patients and their relatives in a friendly and welcoming manner and was able to address their immediate anxieties by asking appropriate questions concerning their clinical condition, in a compassionate and timely way.
- Emergency nurse practitioners (ENPs) and support staff were skilled in communicating with patients and their relatives, particularly in relation to children and young people. Interactions were compassionate and caring.Patients and relatives told us how happy they were with the care they had received throughout their stay at MIU. One relative said they "The ENP was very kind and had kept them fully informed about the care and treatment of their family member".
- Another relative said, "My child was very frightened of attending the minor injury service and the nurse (ENP) spent a lot of time reassuring them about the treatment (X-ray) they were going to have. This could have been a frightening experience for my child but when we left the MIU my child said they would be happy to return if they fell over again".
- The Friends and Family Test (FFT) was in place in MIU and patients were asked to record their experiences on an electronic tablet, which had additional space for patient comments. 98.3 % of patients attending the MIU between July and September 2016 said they would recommend the MIU service to others. Patients comments said, "A very caring service and treated with the greatest respect" and "Thank you for the very prompt, kind and understanding treatment" and "I was treated with dignity and respect by very caring staff".
- Patients we spoke to told us that when they experienced physical pain or/and discomfort, staff responded in a friendly and compassionate, timely and appropriate way.One patient told us pain was not an issue as it was very well controlled by staff.
- ENPs supported children and their parents to help them to understand procedures.When having a plaster cast applied to a fractured ankle we observed a child was supported emotionally by the ENP around the changes to their mobility and was encouraged to use mobility aids (crutches) appropriately before leaving MIU. Advice and guidance was given to the parent to enable them to support their child out of hours in the event of complications developing.

Understanding and involvement of patients and those close to them

- ENPs explained care and treatment to patients. For example, we saw an ENP explaining a procedure to a patient who was worried about an injury to their hand, which had been treated in another hospital while the patient was on holiday. The ENP continually reassured the patient as their dressing had become wet during their morning shower. The ENP redressed the injury and assured them no additional harm had been incurred.The ENP advised the patient on how to protect their dressing when undertaking a shower. The patient said "I feel so relieved having seen the nurse (ENP) and know what to do to protect my dressing when I next take a shower".
- We saw staff allowed time for questions from patients, relatives, and checked understanding when procedures were explained to them.

Good

Are services caring?

- Parents said they were kept well informed and we saw age appropriate communication with children. A child told us they had been involved in their own care and the parent said “The nurse

  (ENP) saw my son immediately and talked directly to him about his injury rather than talking to me which made me feel that my son’s injury was being taken seriously”.

Emotional support

- ENPS were able to build relationships very quickly with patients and we saw evidence of this throughout our inspection. Patients were assessed with regard to their emotional needs as well as their physical needs.
- During our inspection, a patient attended the MIU to request support and guidance for their relative to administer a topical medicine (to the patient) as they could not administer it themselves. The ENP reassured the patient and relative and made arrangements for them to be seen by their local GP practice the next day.

Good

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary

We rated responsive as good because:

- The minor injury service (MIU) was planned to meet the needs of all patients, including those who were vulnerable or who had complex needs.
- 99% of patients were treated, discharged or transferred within four hours in the last 12 months.
- The average time to treatment was 47 minutes.Waiting times were constantly monitored in real-time by clinical staff.
- Children and young people were seen on arrival in MIU and triaged (assessed) within 15 minutes.
- Staff were aware of the complaints policy and provided clear information to patients about how to make a complaint or raise concerns.

However:

The percentage of patients who left the department without being seen was not captured by the MIU clinical patient information system.

Planning and delivering services which meet people's needs

- The minor injury service was provided in a purpose built minor injury unit (MIU) based at Clevedon Community Hospital which had opened in 2013 after previously being part of the older hospital building. MIU provided easily accessible unscheduled care to adults and children aged over 12 months with minor illnesses and injuries. The opening hours were 8am to 9pm, seven days a week, which included bank holidays.
- The MIU was a walk in service with an average waiting time of 47 minutes. Patients told us they appreciated the short waiting times in comparison to the local accident and emergency departments. Patients were not required to be registered with a local GP to attend MIU.
- Staff told us attendances had increased from 96 a week in 2014 to 230 a week by October 2016.
- Patients and staff were able to access an onsite café staffed by volunteers.
- X-ray facilities were provided by a third party provider and were not always available. The X-ray department closed between 1pm and 2pm and at 5pm on weekdays. There was no X-ray service available at weekends. Most patients we spoke with were happy to come back the next day (during weekdays) but were unhappy there was no weekend service.

Equality and diversity

- Staff told us it was difficult to find an interpreter quickly via the telephone translation system that was in place. Therefore, the MIU used a recognised resource, which contained commonly used medical phrases in 30 different languages to help in the assessment of a patient's clinical condition.
- There was a drop-off point close to the entrance of the MIU to assist people with disabilities and mobility problems.
- There were disabled parking spaces close to the entrance of the MIU and there were empty spaces throughout our inspection.
- Equality and diversity training was delivered at staff induction.

Meeting the needs of people in vulnerable circumstances

- We saw evidence that all staff had undertaken training in the specific needs of people with dementia and learning disabilities and the involvement of families was encouraged.
- Staff said additional time was given to patients with complex needs and there were close links with community services to provide ongoing support if it was required

Access to the right care at the right time

- The organisation consistently exceeded the national standard, which requires that 95% of patients are

Good

Are services responsive to people's needs?

discharged or transferred within four hours of arrival at urgent care (MIU) and emergency departments. The organisation had achieved 99% against the national standard.

- Waiting no more than four hours from arrival to departure and how long patients wait for treatment are important indicators in minor injury unit performance. A short wait will reduce patient risk and discomfort. The national target is a wait time of below 60 minutes and MIU consistently achieved this target with an average wait to treatment time to treatment of 47 minutes for the period April 2015 to March 2016.
- There were processes in place to ensure waiting times were not lengthy. If waiting times were, increasing staff would advise the clinical lead who would seek support from another staff member or help out themselves.
- The shortest daily average waiting time to see an ENP in November 2016 was 33 minutes and the longest was one hour and twenty minutes.
- The system was unable to capture all patient activity undertaken in the minor injury service. For example, the number of unplanned re-attenders within seven days and the number of patients leaving the unit without being seen.The clinical leads were working with the information technology (IT) to improve current service provision to enable all MIU activity to be monitored to support development of urgent care services in the future.
- All children that presented at MIU with a minor injury were initially observed on arrival by an emergency nurse practitioner (ENP) and assessed (triaged) within fifteen minutes of arrival. If the wait to be seen by an ENP exceeded one hour then children took priority over adults waiting, but this was dependent on clinical need.
- X-ray results were immediately reviewed by ENPs who had undertaken the appropriate training.This reduced delays in accurate diagnosis and appropriate treatment.
- The receptionist asked each patient attending the minor injury service, where they would have gone to if the MIU was closed. This enabled managers to demonstrate the degree to which they were reducing demand on emergency services and GPs.
- All attendances to MIU were unplanned and were recorded as such, no matter how many times they attended the minor injury service. Although all previous visits were reviewed by the clinicians when they were seen this was not captured by the clinical patient reporting system.
- There was a limited number of patient information leaflets available for a range of conditions but we were told MIU was awaiting the delivery of new leaflets developed by the organisation with input from MIU.

Learning from complaints and concerns

- There were no formal complaints received about MIU in the last 12 months.
- The clinical leads told us complaints would be handled in line with the organisations complaints policy. If a patient or relative wanted to make an informal complaint, they were directed to the person in charge of the department. If the concern was not able to be resolved locally, the patient was referred to the Patient Advice and Support team (PALs) that would formally log their complaint and attempt to resolve their issues within a set period of time.
- Information about how to make a complaint was displayed in public areas in the MIU. We saw that learning from complaints was discussed at team meetings and governance meetings.

Good

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

We rated the service as good for well-led because;

- Staff respected clinical leaders. They were knowledgeable about quality issues and priorities, understood what the challenges were, and took actions to address them.
- There was a strong sense of teamwork between all staff and staff were proud of the standard of care they delivered to patients in the minor injury service (MIU).
- Quality monitoring was well structured with risks and quality being regularly monitored and action taken if necessary.
- MIU was included in governance meetings held within the wider organisation.
- The development of the 'social enterprise' model had encouraged wider engagement with people in North Somerset.
- Clinical leaders were keen to develop innovative practices in the minor injury service.

Leadership of this service

- There were 1.2 whole time equivalent (wte) emergency nurse practitioners (ENPs) who reported to a locality manager and provided managerial and clinical leadership for the minor injury service.The clinical leaders both worked clinically in MIU and had a full understanding of the caseload and issues experienced by staff.
- Staff told us the leaders of the service had the knowledge, skills and capability to lead the service.
- Staff told us there was flexibility amongst staff and they were happy to cover shifts at short notice.Staff could tell us who the locality manager and executive and non-executive directors were as they visited the unit regularly and said the visits were helpful.

Service vision and strategy

- The organisation is an employee owned community interest company, which provides NHS community health services to the population of North Somerset. Organisational values were developed with staff from across the organisation. Clinical leaders and ENPs in MIU were able to tell us about the vision and strategy (for the organisation) and their role in supporting the strategy. The two clinical leaders in MIU were elected by staff to the roles of chair and vice chair of the staff council in July 2016.

Governance, risk management and quality measurement

- The clinical leads in MIU carried out a wide range of monthly reviews in MIU. For example, adverse incidents, compliance with local and national standards, safeguarding training, reviews of complaints, compliments, and guidance from the national institute of care and excellence (NICE).Following the review a service report was sent to the locality manager responsible for the service.We saw evidence of incidents, complaints and concerns discussed at locality team meetings.
- There was no risk register specific to MIU. Any serious risks were included on the organisations risk register. A risk around the lack of a named emergency department consultant to support clinical supervision for the clinical leads in MIU had been entered on to the organisation's risk register in October 2016. We noted the risk had been forwarded to the clinical cabinet for review.
- The organisation was unaware of some governance issues in relation to medicines in the minor injury service. For example, the requirement to hold a Home Office licence with regard to the possession of controlled drugs and compliance with the Misuse of Drugs Act 1971 and its associated regulations regarding the supply of controlled drugs to the MIU.

Culture within this service

- Staff told us they were listened to if they raised concerns and there was a 'no blame' culture in the unit.MIU had won the 'team of the year' award in 2016, and were nominated by staff working in the unit.

Good

Are services well-led?

- Patients said staff would always go the 'extra mile' and nothing was ever too much trouble for them.
- We heard from staff members that patient care was always at the forefront of what they did and improving patient care was the main vision of all staff working in the service.

Public engagement

- Clinical leaders told us that being part of a 'social enterprise' model had encouraged wider engagement with people in North Somerset.For example, the clinical leaders provided a range of briefing sessions on general health topics to help people live full and active lives in their local community.
- A recent refurbishment in MIU had used local contractors who worked closely with the clinical leads to ensure there was no interruption to clinical services.
- The minor injury service used patient surveys to capture feedback from patients. The unit had a clearly displayed electronic tablet, which was attached to the wall. Staff assisted patients if they were unfamiliar with the technology and they received a lot of feedback which was acted upon and fed back to patients.For example, improved signage in the unit.

Staff engagement

- Staff we spoke with said they were involved in the running of the minor injury service and their views were taken into account when decisions were made about the service. For example, staff had been involved in developing the clinical aspects of the computer system and the location of the café in the hospital grounds.
- Monthly team meetings and one to one meetings were held between the staff of the minor injury unit. Staff reported that they felt happy to raise issues and concerns about the unit with senior staff.Clinical leads also attended meetings with other heads of service in the organisation.
- Staff were aware of the staff council and were proud that their clinical leads had been nominated as chair and vice chair.

Innovation, improvement and sustainability

- Clinical leaders were keen to drive innovation and improvement in the minor injury service.We saw example of where staff had been encouraged to take on new and challenging roles to help develop the service. For example, an ENP had recently undertaken the infection control lead for the unit.
- The clinical leaders had implemented intranasal pain control for children, which enable analgesia to be administered in a timely and painless way and with the minimum of disruption to an already distressed child. The medicines management committee had worked closely with the clinical leads to develop protocols and standard operating procedures (SOP) to ensure the appropriate administration of intranasal pain control.