Wiltshire Health and Care LLP

1-2642739822

Urgent care services

Quality Report

Chippenham Community Hospital
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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)
1-2699740288	Chippenham Community Hospital	Minor Injury Unit	SN15 2AJ
1-2700381463	Trowbridge Community Hospital	Minor Injury Unit	BA14 8PH

This report describes our judgement of the quality of care provided within this core service by Wiltshire Health and Care LLP. 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 Wiltshire Health and Care LLP and these are brought together to inform our overall judgement of Wiltshire Health and Care LLP

Summary of findings

Ratings

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

Summary of findings

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Overall summary

Overall rating for this service

- There was no assurance around the safe temperature of medicines stored at room temperature.
- Some of the patient group directions relied upon by staff were not the current versions.
- There was no formal clinical supervision for staff on a regular basis.
- Staff recruitment and retention of nursing staff was an issue for the organisation.
- The service relied heavily on bank and agency staff to cover duties required.
- There was not an effective governance framework within both units.

However;

- Patients received safe care. They were promptly assessed to ensure that serious or life-threatening injuries were identified or excluded and that patients were appropriately prioritised. Accurate and comprehensive records for patients were maintained.
- The minor injury units were clean, well maintained, and designed to keep people safe.
- People were protected from abuse and avoidable harm. Staff had good knowledge of safeguarding procedures.
- There were mostly safe levels of well-trained, experienced and skilled staff, supported by agency staff.
- Care was effective and patients had good outcomes.
- Staff delivered care with kindness and compassion. Staff made sure the patient was at the centre of the service, and offered emotional support.
- Staff took steps to support vulnerable people.
- Complaints and concerns were listened to and acted upon to improve services.
- Results of the NHS Friends and Family Test showed almost everyone who responded would be likely or extremely likely to recommend the service.
- Opening hours of both units had been reduced, in consultation with commissioners, to ensure patient safety and correct staffing levels.
- Patients had their needs assessed, care planned and delivered in line with evidence-based guidance and best practice. Patients told us their pain was assessed and they were given adequate pain relief.

Summary of findings

Background to the service

Information about the service

Urgent care is provided in two minor injury units (MIUs) at Chippenham Community Hospital and Trowbridge Community Hospital. Services are provided for people who need treatment for minor cuts and lacerations, animal bites, bruises, strains and sprains, simple fractures and dislocations. The unit also treated minor burns and scalds, head injuries (if the person is not unconscious or intoxicated), minor eye injuries, splinters and other foreign bodies in the skin, eye, ear or nose.

Each MIU is open seven days a week from 7 am until 11 pm. The X-ray facilities are provided by a local NHS organisation and operate from 9 am until 5 pm, Monday to Friday. There are no X-ray facilities at weekends or some public holidays.

In late 2016, MIU opening times were reduced from 24 hours to 16 hours a day at one unit and two hours at the other to harmonise opening hours. This was due to concerns about sufficient numbers of staff to provide the service safely at all times. This change was agreed with commissioners of the service and took place following staff consultation and public engagement.

In the 11 months from July 2016 to May 2017, the MIUs saw 33,229 patients – 15,524 at Trowbridge, of which 40% were children, and 17,705 at Chippenham, of which 40% were children.

We visited the MIU at Chippenham on 28 June 2017 and at Trowbridge on 29 June 2017. We returned unannounced to both MIUs on 10 July 2017. During our inspection, we spoke with the head of operations for specialist services (of which the MIUs were a part), the operational lead for both MIUs, two reception staff, eight nurses, four healthcare assistants, a paramedic, an administrator and a member of the domestic staff. We met the X-ray staff at the Chippenham unit. We heard from five patients, their relatives and carers during our visits.

Our inspection team

Our inspection team was led by:

Chair: Julia Blumgart, invited independent chair.

Team Leader: Alison Giles, Care Quality Commission.

The team included CQC inspectors and a specialist nurse with experience in emergency care.

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 the service, we reviewed a range of information we hold about the organisation, asked the

Summary of findings

provider to send us a wide-range of evidence, and asked other stakeholder organisations to share what they knew. We carried out announced visits on 27 to 29 June 2017 and returned for an unannounced visit on 10 July 2017. During the visits, we met with a range of staff who worked within the services, such as nurses, paramedics, healthcare assistants, receptionists, and members of the management team. During our visits we took time to observe how patients were being cared for, we talked with people who used the services, carers and/or family members. We reviewed treatment records and other information about people's care.

What people who use the provider say

Feedback from the NHS Friends and Family Test showed that that almost everyone who responded would be likely or extremely likely to recommend the service. Patients, relatives and carers we spoke with said:

- "we receive a more personal service than in larger emergency departments"
- "staff are extremely polite and caring"
- "staff connect with you and put you at ease"
- "nice and helpful and nothing too much trouble"

Good practice

In Trowbridge Hospital MIU, staff used 'distraction boxes' for children. A charity supplied them on the request of a nurse working on the unit. The toys and games could be cleaned and any broken or missing items replaced by the charity. We also saw the staff nurse give children their own colouring book and pencils to keep them amused and which they could take home.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the service MUST take to improve

- Improve its governance procedures for MIUs in relation to
  - Low incident reporting rates.
  - Irregular team meetings.
  - Lack of a specific MIU risk register.
  - Improve understanding of the quality and safety performance of the unit for all staff.
  - Ensure routine audits, for example, consent, patient notes and medicines are regularly undertaken.

Action the service SHOULD take to improve the MIUs

- Store all medicines in clinical rooms in MIU are monitored and kept within their recommended temperature range.
- Review all patient group directions and check that staff sign them as read and understood.
- Review the training requirements of the PGD for emergency contraception.
- Monitor the use-by date of all medicines.
- Record the use of prescription pads in the Chippenham minor injury unit consistently and document them securely.
- Ensure the covers of the soft chairs in the children's waiting areas in Trowbridge MIU are repaired or replaced to enable thorough cleaning.
- Use a recognised and auditable triage tool in the MIUs.
- Ensure all staff in both MIUs have access to regular clinical supervision.
- Ensure that all staff at Chippenham MIU have an annual appraisal
- Obtain child-appropriate emergency bags for each MIU.
- Enable staff in the minor injury units to attend formal clinical and safeguarding supervision in line with policy.
- Ensure mandatory training in MIUs meets the compliance target of 90%.
- Train relevant staff in paediatric basic life support as recommended by the College of Emergency Medicine.

Summary of findings

- Address the backlog of discharge documentation and delayed discharge summaries to other healthcare professionals after a weekend if significant amount of agency staff used.
- Ensure consent is properly documented on the adult and paediatric consultation documentation.
- Review MIU consultation documentation to ensure if a patient does not have capacity to consent, it is clearly documented.
- Monitor and report on a key performance indicators for the re-attendance rate within the minor injuries units, analyse the reason for the high number of re-attendances, and provide assurance that patient outcomes are satisfactory.

Wiltshire Health and Care LLP

Urgent care services

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

By safe, we mean people are protected from abuse and avoidable harm.

We rated the safety of urgent care services as requires improvement because:

- Staff could not provide assurance that medicines stored at room temperature were kept within recommended temperature ranges.
- Some of the patient group directions relied upon by staff were not the current versions.
- Reporting of incidents was low but the organisation had a plan in place to address this.
- Recruitment and retention of nursing staff was an issue for the organisation.
- Staff in the minor injury units were not always attending the formal clinical and safeguarding supervision in line with policy.
- Compliance with mandatory training did not meet the organisation's target of 90%.
- The receptionists at Chippenham MIU should be supported to identify injuries that needed to be brought to the attention of a nurse immediately.

However,

- Lessons were learned and improvements were made when things went wrong.
- There were reliable systems to keep people safe from abuse.
- The environment was clean and well maintained. Staff complied with infection prevention and control procedures.
- The organisation was aware of staff shortages in the units and this was included on the operational risk register. Safe staffing levels were maintained through use of bank and agency staff.
- Patients were assessed promptly to ensure that serious or life-threatening conditions were identified or excluded and patients were appropriately prioritised by risk.
- There were effective systems for the ordering and secure storage of medicines, including medical gases.
- Medicines requiring refrigeration were stored within their recommended temperature range but room temperature was not monitored.
- Patient records were complete, accurate, legible and up to date. Staff completed assessments and risk assessments for patients.

Requires improvement

Are services safe?

Detailed findings

Incident reporting, learning and improvement

- Staff understood their responsibility to raise concerns, record and report safety incidents, concerns and near misses. For example, staff felt managers had listened and learned from an incident involving a patient who breached the four-hour wait in a MIU. Staffing was increased to cover the busiest period to prevent recurrence.
- Staff told us they were encouraged to report incidents and they received feedback following investigation. However, in the quality update of January 2017, Chippenham Hospital MIU only reported one incident. Staff told us they did not always complete incident reports, for example, for staff shortages, due to lack of time. The provider acknowledged the under-reporting and had a plan to address this.
- The provider's quality reports identified themes from serious incidents, lessons learned and actions taken.
- Senior nurses investigated incidents and lessons learned were discussed at team meetings. There was feedback to staff from incidents, so learning was shared and implemented. Minutes from team meetings at units recorded discussions of incidents that had been reported each month as a standing agenda item. However, team meetings were not regular; the last one, for both units, was January 2017.

Duty of Candour

- Staff demonstrated their awareness of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, introduced in November 2014. This Regulation requires the organisation to notify the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. All staff at Chippenham MIU and 90% of staff at Trowbridge Hospital MIU had attended duty of candour training. Staff could describe the principles of this legislation and recognised when they would be applied.

Safeguarding

- Staff were able to tell us about the systems, processes and practices they followed to keep people safe, based on national standards and guidelines. All staff attended training to an appropriate level for their role. All MIU clinical staff attended level three safeguarding children and level two safeguarding adults' training as required. However, there had been some gaps in the recognition of support and leadership among the staff. The organisation told us interim arrangements had been made, but the staff were not able to describe these. At Chippenham MIU, the safeguarding adult lead came to the unit every Monday morning to check if there had been any safeguarding issues over the weekend. This was a new process recently established by the new post holder.
- Staff were aware of their responsibilities to safeguard their patients from harm. They gave us examples of how they had recognised risk and liaised with other professionals for further advice and raise concerns. This included working with safeguarding agencies such as the Multi Agency Safeguarding Hub and local authority safeguarding.
- Electronic patient records alerted staff if there was involvement with a patient from social services, including child protection.
- The named nurse for safeguarding children offered group supervision to support staff in their practice but found the sessions were not always well attended due to unpredictably high pressure of work. This meant staff were unable to be released from their duties. Unit managers were informed of planned supervision sessions but staff in Chippenham MIU told us a senior member of staff had been off work for some weeks and they were not aware of any further dates.
- The safeguarding lead for adults reviewed all reported incidents to identify possible safeguarding issues and where improvements could be made. Learning from practice and serious case reviews was shared with staff in safeguarding newsletters that were on the intranet for staff to review.
- Staff were trained to recognise and deal with specific concerns around children and updated on current guidance. Information about female genital mutilation and child sexual exploitation was included in the level three children's safeguarding training modules. Staff told us of scenarios used that related training to practice and reinforced learning.

Requires improvement

Are services safe?

Medicines

- Staff followed the organisation's policies to manage medicines and medical gases safely. Medicines were stored safely and securely. They were stored in locked cabinets either in the treatment rooms, or in a clinical room. Senior members of staff held the keys.
- Medicines requiring refrigeration were safely stored. Medicines' fridges were at the correct temperature at the time of our visit, and records showed that temperatures were regularly checked and in the correct range.
- The organisation is required to monitor room temperature for storage of medicines before dispensing or administering to patients. This is best practice and provides assurance that the medicines have been stored appropriately. The room temperature where medicines were stored was not monitored or recorded at either unit.
- Best practice is to lock the door to the clinical room containing medicine cupboards at all times, when not in use. The door to the clinical room containing the medicines cupboard in Trowbridge was opposite the nurses' workstation. It had a lock, which was not used and the door was left open. We did not see a risk assessment for not locking the door.
- We looked at a number of the electronic copies of the PGDs available in the organisation; some of the patient group directions relied upon by staff were not the current versions. We reported this to the organisation and they took action to ensure all PGDs were updated. At our unannounced inspection in Chippenham, we found staff had not signed the team signature list to acknowledge the updated PGDs but Trowbridge staff had.
- The organisation employed nurses with the qualifications and competence to prescribe and administer medicines. The MIUs employed a number of nursing staff qualified as non-medical prescribers. These nurses were able to prescribe and administer medicines or write prescriptions for patients to take to a dispensing pharmacy. They were also able to issue medicines from stocks held in the units for patients to take away. This was recorded using the nurse practitioners' prescription section on the medication administration record.
- Patient's allergies were checked by staff prior to medicines prescribed or given. We checked a sample of nine sets of patient records and found allergies documented in all cases.
- Prescription pads (FP10s) in Chippenham were stored securely but there was no recording sheet to monitor their use. We saw good practice regarding the issue of prescriptions where the drug issued was documented in the paper and electronic patient record. Trowbridge staff did not provide patients with prescriptions to take away.
- The organisation was required to monitor use by dates of medicines. The majority of medicines were within their use-by date, although we found liquid medicine that was out of date.
- Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse. We found controlled drugs stored securely and appropriate records kept.
- We found a controlled drug medicine, Morphine oral solution, which was out of date but not replaced. We brought this to the attention of the nurse in charge, as it had not been reordered.
- We looked at the PGDs for Levenolle and Ellaone (emergency contraception) and we were concerned that there was a lack of a training requirement for staff for this medicine.
- Emergency medicines for the treatment of anaphylaxis and basic life support were available in tamper-evident containers. Each MIU had an emergency bag containing medicines for use in an emergency. These were stocked with the relevant medicines in accordance with the Resuscitation Council guidance. The stocks of medicines and other equipment were checked as required to ensure they were all present and were in date for use. We did not see child-appropriate emergency bag.
- Medical gases were checked and ready for use, although one had insufficient recording. However, in Trowbridge there was insufficient racking for some cylinders, which had resulted in some being stacked on top of each other. The oxygen and nitrous oxide kept in the units for emergency use was correctly labelled and there were appropriate signage and safety warnings. However, at Chippenham, the volume of the Entonox was not recorded and there was no expiry date shown.
- Incidents with medicines were investigated and lessons learned. For example, following incidents around

discrepancies in stocks of medicines, an investigation found that poor record keeping was the cause of medicines appearing to be missing from stock. As a result of this, both units maintained stock calculation sheets for all medicines, which had resolved the problem with discrepancies.

Environment and equipment

- Arrangements in waiting areas ensured people were safe. Waiting areas were used for patients attending the MIU as well as other areas of the hospital such as outpatients departments. We saw emergency bells in the waiting rooms in case of emergency. During our inspection, the emergency bell sounded in the waiting room in Chippenham Hospital and several members of staff attended very quickly. Patients were monitored using closed circuit television because the waiting areas were not in the direct line of sight for any staff. There were notices in each unit that told patients CCTV was in operation.
- Staff monitored the CCTV screens but not at all times. In Chippenham Hospital, reception and nursing staff viewed screens and monitored continually when the unit was open. In Trowbridge Hospital, nursing staff viewed the screens at the nurses' station. This monitored the entrance corridors, the adults' waiting area or children's waiting area. At the time of our visit, the screen in Trowbridge Hospital was set to the entrance corridor and not the waiting area. This meant the waiting room was unmonitored. Staff told us if they considered a patient at too much risk in the waiting areas, they would place them in the unit under direct observation.
- Children's waiting areas were separate from adults' waiting areas;
  - In Chippenham Hospital, children had a child-friendly space to wait, which was alongside the adult room.
  - In Trowbridge Hospital, the children had a separate waiting area. Some of the covers of the soft chairs in this area were torn at the seams and would be difficult to keep clean and hygienic.
- Equipment was regularly maintained and a record was kept of its next maintenance date. All equipment was labelled with both its servicing date and portable appliance test (PAT) date. The equipment was managed and maintained through a service level agreement with an NHS trust.
- There was safe disposal of clinical waste. All clinical waste, including sharp instruments, was segregated and stored out of public areas until authorised staff collected it.

Quality of records

- Patients' individual care records were written and managed in a way that protected their safety. Staff initially wrote care records and then transferred them onto the electronic system.
- We reviewed nine sets of patients' care records and found them to be complete, accurate, legible, contemporaneous and to a good standard.

Cleanliness, infection control and hygiene

- Both the units were visibly clean and tidy and had good arrangements for maintaining cleanliness. Both units were cleaned daily by domestic staff and sometimes by nursing staff. We saw cleaning rotas signed and dated, completed in all the areas of both MIUs, including chairs and keyboards.
- We spoke to staff that were clear about their infection prevention and control responsibilities. There was plenty of personal protective equipment on both units, such as gloves and aprons, and staff using it appropriately. All staff complied with the trust's policy and were bare below the elbow.
- There was a protocol for keeping a patient with a possible infectious illness or condition isolated in one of the clinic rooms. The units were able to limit the spread of any infection arriving in their unit.
- Most equipment was in good condition. The waiting area in Chippenham hospital had new chairs however, in the children's waiting area in Trowbridge; some of the covers of the soft chairs in this area were torn at seams and would be difficult to keep clean.
- Hand sanitising gel was available for staff, patients and visitors to use in the units with instructions for use. We saw staff washing their hands between patient contacts using correct hand-washing techniques.
- There were regular audits of hand washing, but where they fell short of full compliance, no actions had been agreed. A member of staff completed hand hygiene audits once a month. The results ranged from 75% to 100% compliance. However, some figures were skewed

due to data collection methods. These audits were returned to managers electronically but staff said they received no results, actions required or feedback on themes.

- Clinical waste was well managed. Each cubicle and clinic room had correct waste bin for clinical and general waste. However, there was no designated waste bin for pharmaceutical waste.

Mandatory training

- Most staff had updated their mandatory training, but not all subjects were yet at the organisation's target level. Staff attended mandatory training in safety systems, process and practices. The mandatory training compliance target for the organisation was 90%. Compliance was as follows;
  - Adult Basic Life Support – 88.2% at Chippenham Hospital, 80% at Trowbridge Hospital
  - Fire safety awareness – 90% at Chippenham Hospital, 84.6% at Trowbridge Hospital
  - Moving patients – 94.1% at Chippenham, 90% at Trowbridge
- Staff at the units were responsible for completing the update of their mandatory training. The provider had a training needs analysis for all staff informing them of the statutory and mandatory training they needed to complete and the associated timeframes. All staff signed up to an electronic training tracker that issued reminder emails when training needed to be refreshed. Managers received a monthly email update on their staff's training status.

Assessing and responding to patient risk

- A nurse initially assessed patients on admission, called triage, in order of arrival, although the units were not using a recognised triage tool. At Trowbridge MIU, the receptionist had a checklist of injuries that needed to be brought to the attention of a nurse immediately. However, at Chippenham MIU, the receptionists told us they had no checklist and relied on their common sense
- Nursing staff assessed patients for risk of sepsis at triage. If a risk was identified, they used an early warning risk assessment tool to record observations and monitor any change while the patient was there. A poster in the resuscitation room showed a pathway for recognition and treatment of sepsis.
- Priority was given to vulnerable patients, for example, patients with dementia, learning disability or a patient with a serious injury.
- Parents we spoke with who had been waiting after triage for an hour and a half with their child told us they were aware staff needed to prioritise patients. They told us how their daughter (on a previous visit) been treated quickly as staff knew her need at that time was more urgent.
- People who attended with minor illnesses were directed to other healthcare providers as appropriate. Any patients with a severe injury were cared for and then transferred by ambulance to an emergency department.

Staffing levels and caseload

- There was a mix of staff with different skills and experience. Emergency nurse practitioners, staff nurses, paramedics and healthcare assistants made up the MIU teams.

- There were mostly safe levels of staffing, although the unit supplemented its own staff with agency workers and bank staff. There was no evidence to suggest the units were unsafe due to staffing levels, but there were issues with the agency staff not being able to cover all duties required. MIUs, both locally and nationally have experienced shortages of suitably skilled staff. Recruitment data from February 2017 showed both MIUs had a combined vacancy rate of 25% whole time equivalent registered nursing posts. The provider developed a staffing recruitment and retention strategy. This included a re-banding of ENPs to band seven, review of the ENP job description, consideration of apprenticeships, and two band five developmental posts. We were shown evidence of a new two-year development programme for newly qualified nursing staff. Two new members of staff have been recruited and start in September 2017.
- Bank/agency staff were used for times of unexpected staff absence and had undertaken an induction programme before they were able to work a shift. Each unit had an 'agency staff orientation checklist' completed for new agency staff. This was faxed to the agency supplying the worker, for their records.
- Staff handovers took place at shift change times and included all relevant information such as the number of patients waiting and concerns about patients.

Requires improvement

Are services safe?

Managing anticipated risks

- Staff ensured patient safety when demand for the service exceeded the capacity of the units. There was an escalation plan for staff to follow to manage the service when waiting times were becoming too long. The I-Respond red book contained a flow chart of who to contact and when.
- Staff followed the organisation's protocol to maintain security of staff and others. If there was a threat of violence, staff told us they knew how to respond.
- Each MIU had an 'I Respond' book. This detailed how staff dealt with issues such as major incidents, bomb threats, lockdown of the unit, staffing levels, business continuity, safeguarding and decontamination. It also covered booking taxis, contacting community teams out of hours and violent patients and/or family.
- Fire exits were clearly marked and fire doors were not obstructed. Staff had attended their fire training, 93% for both units.

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

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

We have rated this service as good because:

- Patients had their needs assessed, care planned and delivered in line with evidence-based guidance and best practice. Staff had access to a range of national guidance, referral pathways and local protocols.
- The organisation monitored outcomes for patients care and treatment during assessment, diagnosis and referral.
- Patients received assessment and treatment of their pain promptly after arriving at the department.
- Teams worked together to provide the most appropriate care for their patients. Staff had access to advice from other teams and partner organisations.
- Staff were suitably qualified and experienced to undertake their role. Staff had a variety of skills and was supported to update them.
- Staff followed legislation and guidance when seeking consent from patients before they provided care or treatment.
- Patients we met felt they had received good treatment and advice.

However:

- There was no regular formal clinical supervision provided for staff. However, the head of operations provided supervision for managers.
- Not all staff were trained in paediatric basic life support, as recommended by the College of Emergency Medicine.
- Staff faced a backlog of discharge documentation after a weekend when the MIUs were staffed mainly by agency staff. This delayed discharge summaries to other healthcare professionals.
- Documentation to ensure if a patient does not have capacity to consent, how their consent was gained, was not clear.

Detailed findings

Evidence based care and treatment

- People had their needs assessed, care planned and delivered in line with evidence-based guidance and standards for best practice. Guidance from the Royal College of Emergency Medicine was used to assess and diagnose patient's needs. Experts within the organisation and within partner agencies were able to provide guidance for the service. This included pharmacists, safeguarding specialists and children's nurses.
- Staff told us they were able to access the organisation's protocols that were based on evidence of best practice. However, the system had recently changed to reduce the use of paper versions and they were stored on the intranet. When we asked to view them, staff had difficulty finding them.
- Patients were prioritised using triage processes in a timely way that met standard guidelines produced by the Royal College of Emergency Medicine. However, they were not using a recognised tool for triage.
- Written information provided for patients was specific to their injury. This was clearly written with diagrams to aid understanding.
- Systems supported good quality care that recognised any errors through additional reviews early. For example, emergency nurse practitioners were able to order and review diagnostic X-rays. A radiographer also reviewed these X-rays and provided feedback on any missed fractures. This was fed back to the nurse and appropriate action was taken. This usually involved calling the patient back for further treatment to be provided. The provider of X-ray services gave the units written reports on X-rays taken within seven days but could be contacted via a 'hot desk' for an immediate opinion.
- Patients were issued with guidance leaflets for their injury. These included head injury advice, care of plaster casts, insect bites and simple burns among other topics.

Some were provided by other organisations such as Public Health England. The leaflets were well written and clear; however, some were poorly photocopied and lacked the provider's logo.

Pain relief

- Patients' pain was assessed by staff at triage using a range of assessment tools appropriate to the individual. We observed staff asking older children and adult patients to rate their pain using a numerical score, with 10 being the worst pain. If the patient could not describe their pain (as they might be a very young child or had cognitive impairment), staff would use a facial recognition scale to help determine if the patient was in any pain. Staff would also ask parents, guardians or carers for their views, or anything they might have recognised to indicate the patient, who may not be able to communicate, was in pain. This process met national standards for pain management.
- There were procedures for nursing staff to provide simple analgesia to patients, such as paracetamol. This could be done as soon as the patient had been triaged, and it was safe to do so. This meant patients who may have a long wait had already been given some relief if they were in any pain.
- Patients told us their pain had been assessed and appropriate pain relief provided.

Patient outcomes

- The organisation audited few outcomes for patients care and treatment during assessment, diagnosis and referral. Management of fractures was audited to ensure any missed diagnosis of fractures was identified. If a fracture had been missed, the member of staff was informed for their learning. Other staff discussed this at team meetings for further learning. Other audits included a documentation audit, which was planned for July 2017.
- The organisation monitored trends of unplanned re-attendances but had no confirmed target to indicate effective care. The number of unplanned re-attendances also suggested patients were not always getting the right care and treatment on the first visit. The evidence provided by the organisation did not consider this as a concern in any reports we read. As at May 2017, there were 9.1% of patients re-attending at the Chippenham unit in the year from June 2016, and 8.6% returning at the Trowbridge unit. As a comparison, another local organisation had a target of 5% for unplanned re-attendances at the minor injury units, and reported data of around 2%. The organisation was carrying out a review of the data to determine if it was accurate.
- Patients we met felt they had received good treatment and advice. Some patients had used the service on previous occasions and said their treatment had been effective.

Competent staff

- Nursing staff and paramedics in substantive roles were suitably qualified and competent. They were supported to develop their knowledge and skills. However, a lack of staffing on the units had meant that opportunities were not always possible to take up. For example, staff had missed safeguarding supervision because of work pressures and two staff had attended in their own time.
- Clinical supervision provides an opportunity for staff to reflect on and review their practice, change or modify their practice, identify training and continuing development needs. We found there was no provision of formal clinical supervision in either unit.
- At 1 April 2017, all staff at Trowbridge unit had their annual appraisal; however, only 71.4% of staff had their annual appraisal at the Chippenham unit.
- Temporary staff were provided with an induction and had specific qualifications and skills relevant for working in minor injury units. Their induction did not include enabling agency staff to add information onto the electronic record keeping system, which affected the timeliness of discharge letters being sent. However, they were able to read the electronic records for any issues they needed to be aware of, for example child protection.
- At Chippenham, work experience students were given an introduction pack. This was a useful document that told them all they needed to know about the unit. It contained a welcome to the unit, personal information about the worker including their emergency contact numbers. There was also useful helpful information about the hospital including infection, prevention and control and hand hygiene.
- Staff had a variety of skills and were encouraged to develop. Nurses had skills in paediatric care, plastering for making splints, and experience in emergency care.

Good

Are services effective?

One nurse we met had just completed the emergency nurse practitioner qualification. A student nurse at Trowbridge Hospital MIU told us how well staff had supported them to develop skills and confidence.

- Training was provided for staff and identified as both mandatory and role-specific. The role-specific training included ear irrigation, issuing crutches, and removal of foreign bodies from eyes. Some nurses had completed additional competencies and become emergency nurse practitioners. In both MIUs, several nurses were registered children's nurses.
- Not all staff had updated their basic life support training. Data for May 2017 showed that 80% of Trowbridge MIU staff and 88% of Chippenham MIU staff had updated their adult basic life support training. This was below the organisation's target of 90%. Paediatric immediate life support training is recommended by the College of Emergency Medicine for staff of minor injury units to attend. However, this was not part of the training matrix for staff at the MIUs. Paediatric basic life support training had been attended by 75% of staff but this was below the organisation's target of 90% attendance.
- New staff were provided with induction training and a protected period of time to learn their new role. New staff would not be counted in the staffing numbers until they had completed an induction. The length of this induction would depend upon their previous experience. We were shown evidence of a new two-year development programme for newly qualified nursing staff. The first two new members of staff were due to start in September 2017.
- Staff were given time for professional courses. A number of the staff had completed or were booked to attend the following courses:
  - Minor illness and minor injury in children (known as MIMIC – a professionally delivered, accredited course).
  - Physical assessment and clinical reasoning for both adults and children (known as PACR – a professionally delivered, accredited course).

Multi-disciplinary working and coordinated care pathways

- There were good working relationships with other services to support a patient's pathway to other health services. We saw how staff communicated with the ambulance service to ensure a patient attended the most appropriate emergency unit for their needs with the least disruption.
- There was a systematic approach to working with other organisations to improve patient experience and outcomes. The MIUs had developed strong links with healthcare partners in secondary, primary and pre-hospital care. The out of hours GP service was co-located within both MIUs. There was a range of referral pathways and access to support and advice from these partners, as well as ongoing dialogue and feedback to ensure continuing cooperative working and suitable onward referral.
- Staff followed systems to inform other professionals of a patient's attendance at minor injury unit. This included letters to GPs, school nurses, health visitors and referrals to social care. It allowed professionals to offer support to patients and their families in a timely way.
- There was access to X-ray services in both units, provided by a local NHS trust. There was a coordinated approach from the minor injuries' staff that referred patients for an X-ray. There was a good relationship between the teams and a helpful and cooperative approach, to the benefit of patients.

Referral, transfer, discharge and transition

- Staff supported patients to access the relevant service for their ongoing care needs. There were situations when patients needed support from a GP service. The patient could choose to see their own GP, otherwise staff were able to refer them to the out of hours service (which was located in the same hospital) to ensure they were seen.
- Other services were available to offer advice about the care of a patient. This included paediatricians at a local district hospital and local GPs who could be contacted by telephone. Staff told us that if a patient presented with chest pain, they would fax the electro-cardiogram tracing for an expert opinion to one of the local accident and emergency departments, and, if necessary, refer the patient on.
- Staff followed procedures for urgent treatment for more serious conditions such as complex fractures and head injuries, by arranging transport to an accident and emergency department. Patients were able to wait at the unit until their transport arrived.

Good

Are services effective?

- Patients were given guidance leaflets for their injury. These included head injury advice, care of plaster casts, insect bites and simple burns among other topics. Copies of records were given to the patient or ambulance crew to take to the emergency department if they needed to attend.

Access to information

- In most cases, staff had access to information needed to deliver effective care and treatment including care pathways. Some of these were posters on the wall in the resuscitation room; all were current. They were also available electronically from two NHS organisations as they shared the same system. However, some staff difficulty finding policies on the intranet as the system had recently changed.
- The I-Respond book on each unit had relevant information and pathways for staff to follow.
- If advice was needed from a GP if, for example a patient could not remember what medication they were prescribed, staff would call the GP, providing they were available, to request the information.
- Paper patient records were available and filed on each unit. Staff also had access to the electronic patient notes and X-rays. The record system had all the information the staff needed about the patient.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Although staff were asking patients for their consent, the patient records used for adults did not contain any evidence that consent had been given. The patient records for children required staff to indicate consent to sharing information had been obtained from either the patient or their parent/guardian. We observed nurses asking patients' permission before they provided care or treatment. Patients were informed of the care or treatment they were consenting for and could describe the reasons for the tests they were waiting for.
- Although staff knew how to treat a patient in their best interests if they did not have capacity to consent, the records did not provide evidence this was done. Most staff had attended training in the Mental Capacity Act 2005 and they could describe their responsibilities to those patients who did not have capacity to consent.
- Staff were clear about gaining consent from children and young people and when to use Fraser Guidelines and Gillick Competency with a young person. Staff were aware of how young people aged above 16 were presumed to be able to give their own consent, unless staff felt they did not have the maturity to do so. For children under the age of 16, staff knew they could decide if the child demonstrated sufficient maturity to give their own consent. When a child was deemed not sufficiently mature to provide their own consent, staff would seek this from the child's parent or legal guardian.

Good

Are services caring?

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

Summary

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

We have rated this service as good because:

- Staff treated patients with dignity, respect and kindness. Patients told us staff listened to them and gave us positive feedback.
- Patients and their relatives were involved in care options. Patients told us their conditions and treatment options were explained to them in a way they could understand.
- Staff showed compassion and empathy to patients, helping them to maintain independence.
- Trowbridge MIU staff used 'distraction boxes' for children, supplied by a charity on the request of a staff nurse working on the unit. These kept younger children entertained in the unit.

However:

- At the Chippenham unit, triage was occurring in the corridor. This was brought to the attention of senior staff who reinforced a previous instruction to use a private room in the department. Triage then took place in a private consultation room to ensure patients' privacy was maintained.

Detailed findings

Compassionate care

- We observed staff treating patients with kindness, courtesy, compassion and honesty, but not always with sufficient privacy. We observed the triage process carried out in a doorway in a corridor of the Chippenham Hospital unit. This did not provide privacy for patients. This arrangement was not a procedure approved by the organisation. When we brought this to the attention of the organisation, they immediately instructed staff to use a private room in the department (also used for private consultation to protect privacy and dignity during physical or intimate care). In other areas, curtains protected privacy and dignity. Trowbridge Hospital staff used individual rooms or curtained cubicles at all times to triage and treat patients. Patients we spoke with in both units felt they had enough privacy when talking to nursing staff and were treated with respect. Patients we spoke with were positive about their experiences at both units. Comments included "we receive a more personal service than in larger emergency departments", "staff are extremely polite and caring", "staff connect with you and put you at ease" and "nice and helpful and nothing too much trouble." Children we spoke with felt they had been spoken to with respect.
- Staff understood and respected people's personal, cultural, social and religious needs. This included being aware of cultural values for patients from their personal or religious beliefs and reacting with sensitivity. Staff told us of how they maintained patient dignity when assessing safeguarding risks such as female genital mutilation or child protection, by feeding assessment questions into conversations.
- Maintaining confidentiality at the minor injury reception desk in Chippenham could be challenging. This was because patients needed to talk through a glass screen and other people may be queuing behind them. People in the queue did not always follow the request to stand back from the window.

Understanding and involvement of patients and those close to them

- Staff explained treatment options to patients in a way they could understand. Adults and children told us they understood their treatment options. Some consultations could be difficult due to lively children who were accompanying their sibling. We observed staff effectively distract a younger child. This action helped the older sibling (patient) and parent to be involved in care options. In Trowbridge Hospital MIU, staff used 'distraction boxes' for children. These were supplied by a charity on the request of a staff nurse working on the unit. The toys and games could be cleaned effectively, and any items broken or missing replaced by the charity. We saw a nurse give children their own colouring book and pencils to keep them amused.
- Patients who used the minor injury units were supported to find further information about their condition if they needed it. We saw patients provided

with an explanation of their injury, recommended treatment options and written advice sheets to take home. Patients were always informed of how to access further advice for their condition.

Emotional support

- Staff demonstrated that they understood how a patient's condition would affect them emotionally and socially. We observed staff showing empathy to patients and discussing how they could maintain their independence at home. Staff were sensitive to patients' needs and ensured they received appropriate advice for further support. This could include directing them to GP services, out of hours support or an accident and emergency department.
- Staff considered people's wellbeing when looking after them. They tried to triage and treat certain patients at the same time should there be any patients who were mentally or physically frail. This was to help reduce the confusion, stress or anxiety that more than one session with a nurse might cause. We met a parent with a child with a learning disability who had sustained a head injury. The child was triaged and treated immediately to lessen anxiety.

Good

Are services responsive to people's needs?

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

Summary

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

We have rated this service as good because:

- Information about the needs of the local population was used to inform planning and delivery of services that provided care closer to patients' homes.
- Service delivery was discussed with commissioners to ensure safe care was provided. Agreement had been reached to reduce the opening times of the MIUs.
- We saw equipment available for bariatric patients, which could be used without singling them out, preserving their dignity.
- Information was available to patients to guide them to alternative options for treatments when the units were closed.
- A non-emergency medical opinion could be sought for patients in the evenings and weekends, as the Out of Hours GP service was co-located within both MIUs.

However:

- There was a restriction on the disabled toilet in Trowbridge Hospital.
- There were certain tasks that agency staff were not able to perform which led to inefficiencies in the service.

Detailed findings

Planning and delivering services which meet people's needs

- Information about the needs of the local population was used in service planning and delivery. The placement of the unit in community hospitals meant care was provided for some people, closer to their homes. Patients we spoke with who lived in the area appreciated the reduction in travelling time to attend the unit.
- Service delivery was discussed with commissioners to ensure care was responsive to people's needs and alternative options were provided to patients. Due to a shortage of staff cover, an agreement had been reached with commissioners to restrict the opening times of the MIUs. Guidance about alternative treatment options was available for patients when the unit was closed.
- There was a service level agreement with local GPs for the MIUs to change dressings for patients at weekends. This provided a local service for people who needed to have access to this, for example, when they were not at work.
- Patients were provided with written information to take home that was specific to their injury. This was clearly written with diagrams to aid understanding. This information had been approved by the organisation, and could be provided in alternative languages on request.
- Waiting areas were large enough and equipped with chairs to accommodate the patients who were waiting. They also had vending machines for hot and cold drinks, a good selection of information leaflets and up-to-date posters, and a television showing the news. Children's waiting areas and were equipped with low chairs, child friendly wall decoration and enough space for lively children.
- Noticeboards for patients were well maintained and up to date. There were notices about domestic violence, abusive relationships, emergency contraception, chaperones, smoking, dental services and translation services.
- Patient information leaflets were only available in English. Staff knew how to access other language information but this took several days to arrange. In Trowbridge MIU, they had the initial consultation document in Polish in response to recognising a large local Polish population.

Equality and diversity

- There were no barriers to patients in relation to their age, gender, race, sexuality, pregnancy status or other protected characteristic. People with mobility problems were able to access each minor injury unit using ramps and automatically opening doors allowed easy access for wheelchair users. Toilet facilities in each unit were designed with grab handles and were accessible for people with mobility problems. However, the accessible toilet in Trowbridge was locked and the key was accessed by asking the receptionist. This could cause embarrassment and reduced equity for these patients.

Good

Are services responsive to people's needs?

- We saw equipment available for bariatric patients, which could be used without singling them out. There was a larger wheelchair and a specially designed trolley available in the resuscitation area.
- If there were any difficulties with patients who spoke English as a second language, translation services were available to help patients to take part in decisions about their care.

Meeting the needs of people in vulnerable circumstances

- Services were planned, delivered and coordinated to take account of people in vulnerable circumstances or those with complex needs. We saw patients with learning disabilities and dementia treated immediately following triage in a private room to lessen their anxiety.
- In Trowbridge Hospital, a nurse used basic sign language and Makaton (a language programme similar to sign language) to improve communication for patients with hearing loss or those who needed support with communication.
- Staff could arrange food for certain patients who had a clinical reason for it while they were waiting. This could be toast from another area of the hospital or food from the hospital dining room.

Access to the right care at the right time

- Patients were able to access initial assessment, diagnosis and urgent treatment in a timely way during the opening hours of the departments. Staffing problems had resulted in the MIUs reducing their opening hours from 24 hours a day to 16 hours a day at one unit, and two hours at the other to harmonise opening times. The organisation had looked at the busiest times in the unit, and consulted staff and the public on the optimal opening hours. An agreement with commissioners had led to opening hours now being between 7am and 11pm. Patients were directed to other services when the units were closed. Information was available to patients to direct them to alternative options for treatment when the units were closed. There were notices at each entrance to the MIUs and big yellow telephones connected directly to the 111 service.
- Rooms were available in both minor injury units for private consultation and when staff needed to use specialist equipment to examine eyes for foreign bodies.
- A speaker system in the waiting areas informed patients when staff were ready to see them for treatment.
- We saw information displayed in the reception areas, which indicated the approximate waiting time to be treated. However, all patients were seen on arrival by a nurse (known as triage) to assess the severity of their injury. This ensured patients were prioritised if they had more serious injuries that needed urgent attention.
- There were arrangements for nursing staff to administer certain medicines to patients. Patient group directions (PGDs) were used for this purpose. These were approved documents permitting authorised members of staff to supply or use medicines with certain groups of patients within approved guidelines. Records showed all substantive nursing staff using PGDs were approved within the PGD. Agency nurses were not able to dispense under the PGDs as they had not received the training or signed up to use them. Some agency staff were independent non-medical prescribers and were entitled to prescribe as required.
- Due to issues with the use of agency staff, some treatment or tests were not provided at all times. Agency nurses could not order X-rays or interpret them, which led to inefficiencies in the service. Certain agency nurses (not those who were non-medical prescribers) were unable to administer medicines for patients under the patient group directions, and were not able to produce letters for the patients' GPs. They were also unable to discharge patients from the electronic patient record, system, which would need to be completed by a substantive member of staff later, providing further inefficiency.
- As there was only one band seven nurse at Trowbridge Hospital MIU able to interpret X-rays, there was an arrangement with the radiographer team at the local NHS organisation to get urgent interpretation.

Learning from complaints and concerns

- There was information available for people who wished to make complaints, raise concerns or pay compliments. People could write to the organisation, send an email, telephone the customer care service, or talk to someone in person. There were leaflets available in the MIUs, which contained all the contact details to do this. The leaflets provided details of advocacy services for people who wanted support to make a complaint. The information was also on the Wiltshire Health and Care website.

Good

Are services responsive to people's needs?

- The organisation listened and responded to complaints and concerns from patients and used them as opportunities to improve the quality of care. The operational lead sent out learning from complaints to both MIUs. This was then discussed at the senior operational meeting. Nursing staff discussed complaints and learning from them in their team meetings, although these were held infrequently of late.

Requires improvement

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

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

We have rated this service as requires improvement because:

- Leadership at unit level was stretched due to staffing shortages.
- Staff we spoke with were not well informed about the quality and performance of the MIUs.
- Team meetings were infrequent, the last held in January 2017.
- The risk register was not used effectively.
- There were limited on-going projects due to the workload of the MIUs and staff shortages. One project we were aware of was the band five nurse development posts.
- There was not an effective governance framework.

However:

- The senior leadership team for both units had the experience. skills and stability to lead the service.
- The MIUs had developed strong links with healthcare partners in secondary, primary and pre-hospital care.

Detailed findings

Leadership of this service

- The senior leadership team for both units had the experience and skills to lead the service. However, leadership at unit level was stretched due to staffing shortages. However, staff told us they supported each other and were proud of the work they did.
- Staff enjoyed working in the MIUs. Both departments had experienced a difficult year with high staff turnover, mainly due to retirements, a local and national shortage of experienced staff leading to difficulty in recruitment. Despite this, morale was reasonable and staff expressed pride in their service.
- Senior managers demonstrated their understanding of the need for good quality and safe care. Recent challenges to staffing levels had resulted in decisions about ensuring services they provided were safe. Actions taken to ensure this included restricting the opening times of the units, with agreement from commissioners.

Service vision and strategy

- The organisation had developed a set of values and behaviours that underpinned their care. They were designed to enable people to live independent and fulfilling lives for as long as possible. Staff told us how their actions contributed to achieving these values and behaviours. They believed they helped encourage patients to feel empowered about managing their health and retaining independence. There was a new printed booklet for staff on values and behaviour being distributed to staff.
- There was a vision for the service in the provider delivery plan 2017-2019. This was for both units to become part of an integrated local urgent care system by becoming urgent treatment centres offering additional services. The plan was to be put forward to the commissioners as part of wider review of urgent treatment care services.
- The philosophy of the service was 'to show commitment in providing evidence-based treatment and care adopting a holistic approach for our patient's needs'. Minor injury units, because of their location, enabled the provider to deliver care close to where most people lived. Staff were able to describe the philosophy of their service.

Governance, risk management and quality measurement

- There was not an effective governance framework. Although staff told us they reported issues and incidents, actual reporting rates were very low, for example about staffing concerns. There were irregular team meetings in which to discuss incidents and learning. There was no discussion of the risk register, which was not being produced by the units. We found

no understanding of the quality and safety performance of the unit, although this was produced for senior staff. There was a lack of routine audit of subjects, such as consent, patient notes, and medicines.

- We found that information was not monitored sufficiently to provide understanding of performance, including safety, quality and patient experience, due to infrequent staff communication through team meetings. The staff meetings held in the units included standing agenda items such as patient safety incidents, complaints and other patient feedback. However, team meetings were not regular. The most recent at the Chippenham MIU was 31 January 2017, and at Trowbridge MIU, was 30 January 2017. The organisation had developed plans to address low attendance rates and had trialled electronic communication updates for staff in place of team meetings. We saw evidence of a number of these communications, which advised staff about ongoing recruitment, absence, and staffing rotas. Although the information was helpful, there were limited topics within these messages and they did not replace a two-way conversation with staff.
- Staff at all levels we spoke with were clear about their roles and they understood what they were accountable for. They identified and escalated clinical risks to managers to ensure care was provided safely.
- The head of operations for specialist services and the operational lead for MIUs represented the service at the executive committee and quality assurance meeting. There had been a recent appointment of a chief operating officer, which would strengthen the representation of specialist services, including the MIUs at the board.
- There was no specific risk register for the MIUs. There was one risk identified at board level, relating to staffing levels on both MIUs. This risk was consistent with the concerns described to us by staff and managers and reflected in the staff survey 2016. In response to these concerns, the provider had re-banded some ENP band six posts to band seven. There was also a recruitment strategy that included a new two-year development programme for newly qualified nursing staff. Two new members of staff had been recruited and started in September 2017.

Culture within this service

- Staff said they knew of the organisation's whistle-blowing policy, and that they were confident to use it.
- Staff felt there was a disconnection between what the service leads believed about how the service and staff were coping, and how this was in reality in relation to staffing levels. However, we found managers were willing to listen to concerns and acted accordingly. Staff also felt the lack of local leadership and poor communication around significant issues affecting them.
- We had concerns about the wellbeing of a member of staff. This was raised with a senior manager who took immediate steps to support the staff member.
- Behaviour and performance that was inconsistent with the organisation's vision and values were usually addressed in a supportive way through performance management.
- There were processes to support staff who were struggling with their role. Other departments, such as human resources and counselling services, were available to support staff and their managers.
- The culture we saw was centred on the needs and experience of patients and those close to them.
- Despite the workload pressures staff remained enthusiastic about their job. In the 2016 NHS Staff Survey for Wiltshire Health and Care, there was negative feedback from staff in relation to staffing levels and pay. Some staff felt undervalued and unappreciated due to pay inequality and this had led to some staff leaving for similar but better paid jobs. Emergency Nurse Practitioners (ENP's) were employed at band six, while nearby NHS organisations graded this post at band seven. Staff told us this was one of the factors with unsuccessful recruitment and retention. In response to these concerns, the provider had re-banded some ENP band six posts to band seven. There was also a recruitment strategy that included a new two-year development programme for newly qualified nursing staff. Two new members of staff had been recruited and started in September 2017
- Both sisters of the MIUs had recognised university leadership qualifications. Staff in the Trowbridge Hospital spoke about the good support they received from their manager. We found that leaders at local and senior level were visible and approachable.

Public engagement

- People who used the services were encouraged to contribute their views about the service they received.

Requires improvement

Are services well-led?

This information was captured using the NHS Friends and Family Test. Feedback forms were handed to each patient at the time of their visit. Feedback forms could be posted or left in the department collection box.

- Each MIU displayed had a 'you said, we did' poster; however, there were no comments displayed on either of these boards, which were relatively new.

Staff engagement

- Staff consultation meetings had taken place to discuss changing shift times in order to manage the workload more effectively.
- Staff did not feel engaged with shift planning as they were required to email senior managers to request time off. Staff felt this was a problem when shifts were very busy.
- Staff notice boards contained information regarding mentor updates, mandatory training dates and safe secure handling of medicines. In the resuscitation room was information regarding safeguarding for adults and children, NICE guidance for CT scans for head injury, an abuse flowchart and guidelines for paediatric observations.

Innovation, improvement and sustainability

- Innovation and improvement was encouraged and supported. Staff told us they always assessed the sustainability of projects to improve care. However, there were limited on-going projects led by staff in the MIUs due to their workload and staff shortages. One project we were aware of was the band five nurse development posts.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **17(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.** **17(2)(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services)** • There was not an effective governance framework for the MIUs. Incidents reporting rates were very low. There were irregular team meetings leading to no discussion or learning. The units did not produce the risk register. There was no understanding of the quality and safety performance of the unit. There was a lack of routine audit of subjects, such as consent, patient notes, and medicines. • Information was not monitored sufficiently to provide understanding of performance, including safety, quality and patient experience.