

# Salisbury NHS Foundation Trust

# Salisbury District Hospital

## Quality Report

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

## Ratings

### Overall rating for this hospital

Requires improvement



Urgent and emergency services

Requires improvement



Medical care (including older people's care)

Good



Surgery

Requires improvement



Critical care

Requires improvement



Maternity and gynaecology

Good



Services for children and young people

Requires improvement



End of life care

Good



Outpatients and diagnostic imaging

Good



Spinal injuries centre

Requires improvement



# Summary of findings

## Letter from the Chief Inspector of Hospitals

Salisbury NHS Foundation Trust provides care to over 240,000 people across Wiltshire, Dorset and Hampshire. This includes general and acute services at Salisbury District Hospital with specialist services including burns, plastics, cleft lip and palate, genetics and rehabilitation serving over three million people. In addition the Duke of Cornwall Spinal Treatment Centre serves South England's population of 11 million people.

Salisbury Hospital has 464 beds and is staffed by approximately 4054 members of staff. They provide care to around 240,000 people across Wiltshire, Dorset and Hampshire.

CQC uses an intelligent monitoring model to identify priority inspection bands. This model looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations. Against this the trust was judged as a low risk, at level six (the lowest level) which it had been at since 2013.

We inspected this trust as part of our programme of comprehensive inspections of acute trusts. The inspection team inspected the standard eight core services as well as an additional service, the spinal service.

Overall, this trust was rated as requiring improvement. We rated it as requiring improvement for safety, being responsive to patients needs and for being well led and good for providing effective care and being caring.

Our key findings were as follows:

### Safety

- Nurse staffing levels in emergency and urgent care, surgical wards, services for children and young people, including the neonatal unit, critical care, maternity and the spinal unit were not always meeting national guidelines or recommendations. This was a risk to patient safety.
- General infection rates in the Trust were low. There had been no new Methicillin Resistant Staphylococcus Aureus (MRSA) since October 2014. Rates of Clostridium Difficile were below the Trust trajectory as at October 2015. However there were occasions where inspectors found variable compliance with infection control procedures such as wearing of gloves and aprons. In a minority of areas equipment was found to be dusty and in one area a commode was found to be dirty.
- The trust was not meeting its target of 85% for the percentage of staff receiving mandatory training.
- In some areas it was found that resuscitation equipment was not being checked every day as required.
- Patient records were not consistently written and managed appropriately. In particular, in the medical services, there was poor documentation of patient's weight and the management of intravenous cannulas and catheters. Charts were not kept secure and confidential at all times.
- In the emergency department patients did not always receive an initial clinical assessment by a healthcare practitioner within 15 minutes of arrival.
- Patients whose condition deteriorated were appropriately monitored with action taken as required.
- There was a strong culture of reporting and learning from incidents. Staff understood their responsibilities to raise concerns, record safety incidents and near misses and to report these appropriately. Staff received feedback and lessons were learnt to improve care. There was a culture of being open and the duty of candour was well understood.

### Effective

# Summary of findings

- In the majority of services, patient needs were assessed and care and treatment delivered in line with legislation, standards and evidence based practice. Performance in national audits was generally the same or better than the national average.
- Mortality rates were as expected at 107 as measured by the Hospital Standardised Mortality Ratio (July 2015) and 107 for the Summary Hospital-level Mortality Indicator (March 2015).
- The majority of staff and teams worked well together to deliver effective care and treatment. Maternity services and theatres could do more to improve multidisciplinary working.
- The majority of staff received an annual appraisal. Improvements were needed to ensure the records about who had received an appraisal were robust.
- Consent and knowledge of the mental capacity act was good however the recording of this needed improvement.

## Caring

- Staff provided kind and compassionate care which was delivered in a respectful way.
- The need for emotional support was recognised and provided by a clinical psychology service.
- In the spinal treatment centre some patients felt ignored and isolated, however also in this unit there were examples of staff going the extra mile such as arranging a wedding to take place in the unit for one patient.
- The majority of feedback from patients and relatives was extremely positive and although the response rate for the friends and family tests were below the national average the number of patients who would recommend Salisbury Hospital exceeded the national average.

## Responsive

- Patient's individual needs were not consistently met. In spinal services there was disparity between the experiences of some patients, whilst some made good use of the gardens and away days others felt lonely and bored.
- Spinal patients waiting for video-urodynamics and outpatients experienced unacceptable waits for appointments and there was little risk assessment of the patients who were waiting.
- The trust did not provide mental health services. Vulnerable patients in the emergency department with mental health needs, particularly children and adolescents who required assessment by a mental health practitioner, did not always receive a responsive service from the external mental health provider teams.
- The environment for children in the emergency department was not appropriate, with them being cared for in the adult area.
- The trust was not consistently maintaining single sex accommodation.
- Patients living with dementia were generally well supported.
- The investigation of complaints was comprehensive however there were areas that could be improved. These related to working with other organisations to provide a single response when required, the development of action planning and learning after the investigation.
- Overall the trust performed well in meeting national targets, including the time patients spent in the emergency department and referral to treatment times.
- The Benson bereavement suite facilities, and sensitive care provided to maternity and gynaecology patients and their relatives experiencing loss were outstanding. These services had been developed with the full involvement of previous patients and their partners.

# Summary of findings

## Well led

- The trust had a governance framework which supported the delivery of care although there were some areas of weakness. The trust had recently undertaken a self- assessment against Monitor's quality governance framework however this had not clearly identified weaknesses or areas for improvement. A review had been undertaken to support board development. Additionally, an external review of the board assurance framework had been completed in May 2015 with 'substantial assurance' being attained.
- Risk registers did not consistently identify all risks, mitigating actions or where it did the actions had not always been taken or where they had the risk had not been updated.
- One of the strengths of the trust was that staff had a strong sense of respect for each other and communicated well, however we heard of informal conversations between staff that lacked documentation to support an audit trail for decisions and actions.
- The trust had experienced a deficit for the first time in its history and staff were anxious about the future. A recovery plan was in place.
- There was an extremely positive culture in the trust, staff felt respected and valued. Many staff had worked in the trust for a considerable number of years and knew each other well. They frequently referred to themselves as being like a family and were very supportive of each other.
- Staff at all levels were very positive about the trust as a place in which to work and this was supported by the staff survey results (2014). Staff had contributed to the development of the trust values and lived these in their work. Staff spoke of being proud of working at the trust, were passionate about providing the best care they could.
- The chief executive had a very high profile in the trust and was known by all staff. Staff felt they were listened to and supported by their managers who were visible in the clinical areas.
- There was a stable executive team with all posts filled on a substantive basis.
- The Governors were fully engaged with the Board, felt supported in their roles and could see their influence when issues were raised.
- Although in the staff survey there had been some reports of discrimination from staff from black, minority and ethnic groups this was not the experience of those spoken with during the inspection who reported feeling supported.
- Innovation and improvement was encouraged and rewarded. There were award ceremonies at which innovative and caring practice was shared and recognised, this was well publicised and appreciated by staff who were proud of their colleagues achievements. Participation in research was good and increasing.

We saw several areas of outstanding practice including:

- The surgery wards had identified link roles for staff in varied and numerous relevant subjects. A nurse and a healthcare assistant had been assigned together to the link role.
- The surgery and musculo-skeletal directorates had regular specialty meetings. A member of the care staff who would not otherwise attend these meetings joined the meeting each time to provide a 'sense-check'. They listened to the content, decided if it made sense and properly described the state of their service.
- There was an outstanding level of support from the consultant surgeons to the junior and trainee doctors and other staff including the student nurses.

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- The maternity services strived to learn from investigations in order improve the care, treatment and safety of patients. This was evident with the robust, rigorous and deep level of analysis and investigation applied when serious incidents occurred. For example, the reopening of a coroners case as a consequence of the maternity service investigations. Further evidence of this was available in meeting minute records. In addition, a wide range of staff demonstrated that learning from incidents was a goal widely shared and understood.
- The Benson bereavement suite facilities, and sensitive care provided to patients experiencing loss were outstanding. These services had been developed with the full involvement of previous patients and their partners. The facilities were comfortable and extensive, enabling patients and their families' privacy and sensitive personalised care and support.
- In the services for children and young people a mobile APP was produced in conjunction with a regional neonatal network to provide information and support for parents taking their babies home.
- Sarum Ward staff worked across the hospital working with a variety of teams to improve services for children and young people. Examples were of developing a DVD for pre-operative patients, using child friendly surveys in other areas of the hospital, supporting any staff with expertise on the needs of children and young people.
- Nurse led pathways were being used. In one example a nurse led pathway was in place for early arthritis, this pathway had been ratified by the Royal College of Nursing. The pathway was evidence based that showed the quicker patients were diagnosed with arthritis, the quicker treatment could be started and the quicker patients could go into remission. This service came top in a national audit for patients with early arthritis. Staff had presented their service at national and international conferences including the Bristol Society of Rheumatology conference in 2015.
- We observed excellent professionalism from staff in outpatients during an emergency situation. Staff attended to the patient that needed immediate help and support. Staff also cared for and supported the other patients who had witnessed the emergency. Patients were moved away from the emergency into another department and kept informed of what was happening and offered lots of reassurance. When the emergency was over, patients were shown back into the waiting area with explanations on the subsequent delay to the clinic.
- The outpatients departments monitored how often patients were seen in clinics without their medical records. From January to July 2015 123,548 sets of patients notes were needed for the various clinic appointments across the trust. Out of these, 115 sets of notes could not be located for the appointment. The department identified that this was because the notes had been miss-filed, staff had not used the case note tracking properly or the notes were off site for another appointment. Overall, patients' medical notes were found for 99.91% of appointments, which was a small increase from the previous two years. This showed that there was an effective system in place for making sure patients' medical notes were available for their outpatient's appointments. Where they were not available, a reason was identified to try and reduce the likelihood of the issue happening again.
- In the spinal centre there were examples of care where staff went above and beyond the call of duty. One example of this was where a patient got married in the spinal centre. Staff went with the patient's partner to collect and prepare food and on the wedding day was picked up by a member of staff in their classic car. The couple were then allowed the use of the discharge accommodation after the wedding.
- The 'live it' and 'discuss it' sessions were fully integrated into the spinal treatment centre. We observed one session where patients and relatives were given opportunities to discuss their concerns as a peer group as well as to professionals and ex-patients. It was clear that patients and their carers were being supported through a difficult time and were being educated on important topics preparing mentally and physically them for discharge.

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

Importantly, the trust must:

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- Review nurse staffing levels and skill mix in the areas detailed below and take steps to ensure there are consistently sufficient numbers of suitably qualified and experienced nurses to deliver safe, effective and responsive care. This must include:
  - a review of the numbers of staff and competencies required to care for children in the emergency department,
  - a review of the arrangements to deploy temporary nursing staff in the emergency department,
  - a review of arrangements in the emergency department to ensure that nursing staff receive regular clinical supervision, education and professional development.
- a review nursing staff levels at night on Amesbury ward, where the current establishment of one nurse for 16 patients, does not meet guidance and is not safe. Other surgery wards with a ratio of one nurse to 12 patients at night must be reviewed. Pressure on staff on the day-surgery unit, when opened to accommodate overnight patients, and still running full surgical lists, must be addressed.
- ensuring there are appropriate numbers of, and suitably qualified staff for the number and dependency of the patients in the critical care unit.
- ensuring there are adequate numbers of suitably qualified, competent and skilled nursing and medical staff deployed in areas where children are cared for in line with national guidance.
- ensuring there are sufficient numbers of midwifery staff to provide care and treatment to patients in line with national guidance.
- ensuring one to one care is provided in established labour in order to comply with national safety guidance (RCOG, 2007).
- Ensure staff across the trust are up-to-date with mandatory training.
- Ensure that all staff have an annual appraisal and that records are able to accurately evidence this.
- Complete the review of triage arrangements in the emergency department without delay and take appropriate steps to ensure that all patients who attend the emergency department are promptly clinically assessed by a healthcare practitioner. This must include taking steps to improve the observation of patients waiting to be assessed so that seriously unwell, anxious or deteriorating patients are identified and seen promptly.
- Ensure staff effectively document care delivered in the patient's healthcare record at the time of assessment or treatment in line with the hospital's policy and best practice. This must include effective documentation with regard to intravenous cannulas and urethral catheters and the recording of patients' weight.
- Strengthen governance arrangements to ensure that all risks to service delivery are outlined in the emergency department's risk register, that there are clear management plans to mitigate risks, regularly review them and escalate them where appropriate.
- Ensure that all actions are implemented and reviewed to reduce patients being cared for in mixed sex accommodation.
- Ensure that daily and weekly check of all resuscitation equipment are completed and documented appropriately.
- Ensure there is a hospital policy governing the use and audit of the World Health Organisation surgical safety checklist. The audit of the checklist must be conducted as soon as an appropriate period of time has passed since its reintroduction. Results must be presented to and regularly reviewed at clinical governance.

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- Ensure there is a sustainable resolution to the issue of holes or damage in the drapes wrapping sterile surgical instrument sets, and all sets are processed and available for re-use to avoid delays or cancellations to patient operations.
- Ensure patient charts are kept secure and confidential at all times.
- Must ensure there is effective management of the conflict between meeting trust targets for performing surgery and the impact this has on patients. Patients must not be discharged home from main theatres unless this cannot be avoided. Surgery must not be undertaken if there is clearly no safe pathway for discharging the patient. Operations must take place in the location where staff are best able to care for their recovery.
- Ensure staff consistently adhere to the trust infection control policy and procedures.
- Ensure that patients are discharged from the critical care unit in a timely manner and at an appropriate time.
- Ensure the process for booking patients an elective beds following surgery is improved and reduce the number of cancelled operations due to the lack of availability of a post-operative critical care bed.
- Ensure that the governance arrangements for critical care operate effectively, specifically that identified issues of risk are logged and that risk are monitored, mitigated and escalated or removed as appropriate.
- Ensure that care and treatment at the spinal unit is provided in a safe way relating to the numbers of spinal patients waiting for video uro-dynamics and outpatient appointments and reducing the risk of harm to these patients.
- Ensure that risks associated with the spinal service are managed appropriately with the pace of actions greatly improved. In particular, to the management of the numbers of patients waiting for video uro-dynamics and outpatient appointments.
- Ensure care and treatment are delivered in a way to ensure that all patients have their needs met which reflects their preferences. This includes the training of agency staff, the availability of physiotherapy and occupational therapy sessions, and the availability of suitable activities for patients in spinal services.

**Professor Sir Mike Richards**  
**Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

### Service

#### Urgent and emergency services

Requires improvement

### Rating



### Why have we given this rating?

The emergency department (ED) was not consistently staffed by sufficient numbers of appropriately qualified, experienced and skilled nursing staff to ensure that people received safe care and treatment at all times. The nursing establishment did not ensure that an appropriate ratio of nursing staff to patients was consistently achieved. This was compounded by the fact the service had a significant numbers of nursing staff vacancies and relied heavily on temporary staff who did not always have the necessary skills and experience to provide safe and effective care. Staffing levels at night were of particular concern and there were concerns about the lack of seniority of medical and nursing staff on duty at night. We had concerns that there were insufficient registered children's nurses employed and there was a lack of assurance that this risk had been mitigated by ensuring that adult trained nurses had received specialist training to care for children. As a result of this lack of appropriately skilled staff, the separate children's area was not being used and children instead received care and treatment in the adults' department which was not an appropriate environment.

Staffing issues impacted on the department's ability to ensure that patients were consistently promptly clinically assessed on arrival in the ED. We were particularly concerned about the delayed clinical assessment of self-presenting patients (adults and children) who were not adequately observed while they waited. We also had concerns that nursing documentation was not always completed to the required standard. Staff shortages may also have affected staff's ability to complete mandatory training. Compliance with mandatory training was well below the trust's target of 85%. We were not assured that nursing staff had sufficient opportunities for ongoing education and development or clinical supervision. People's care and treatment was planned and delivered in line with current evidence-based guidance and standards. We saw good levels of



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compliance with recognised care pathways, including those for sepsis and stroke care. Compliance with protocols and standards was monitored through participation in national audits. Performance in national audits was generally about average compared with other English trusts, with the exception of the Royal College of Emergency Medicine mental health audit, where performance required improvement. There were action plans in place to make improvements where shortfalls were identified. We saw little evidence of local audit. The trust's un-planned re-attendance rate was consistently lower (better than) the England average. This was an indicator that care and communication with patients were effective. Junior doctors felt well supported with regular education and supervision. The lack of senior medical presence in the ED was to some extent mitigated by senior review of all records of patients seen overnight.

The service worked well with other teams and services so that people received seamless care. Care was delivered in a coordinated way, with support from specialist teams and services. There were excellent working arrangements with the Acute Medical Unit, which worked closely with the ED as part of the 'front door team'. There were clear policies agreed with specialty doctors which formalised their supportive role to ED and reciprocal support was offered by ED consultants to junior doctors in other specialties.

We observed that all staff treated people with compassion, kindness, dignity and respect. They responded in a caring and compassionate way when people experienced pain, discomfort or distress. Patients and their relatives were involved as partners in their care. Staff took the time to explain to patients and their relatives about their care and treatment. This was done sensitively and in a way that people could understand. The department had established an outstanding service to support bereaved relatives.

Feedback we received from patients and visitors was overwhelmingly positive. We spoke with many patients and visitors. Unusually, we were approached by some patients who were very keen to tell us how well they had been looked after. This

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feedback was consistent with results from patient satisfaction surveys. Friends and family scores were consistently high, with over 90% of respondents indicating that they would recommend the service. Services were not organised and delivered so that all patients received the right treatment at the right time.

Premises and facilities were largely appropriate for the services delivered; however children were cared for in the adults' department which was not an appropriate environment for them because they were exposed to sights and noise which may cause them stress. The children's waiting room, whilst bright and welcoming, was overlooked by and could be accessed by adult patients and visitors. Patients' privacy and dignity was sometimes compromised on the short stay emergency unit. The ward was cramped and the layout did not always allow for single sex accommodation to be provided.

The needs of patients in vulnerable circumstances were not always met. Patients with mental health needs, particularly children and adolescents, who required assessment by a mental health practitioner, did not always receive a responsive service. This meant that these patients experienced long waits which could be detrimental to their mental health and they were sometimes admitted to hospital unnecessarily.

The department had not taken adequate steps to support patients in vulnerable circumstances, such as those living with dementia.

The ED was consistently meeting national standards in respect of the time people spent in the department, and the time they waited for treatment, although this was becoming more challenging with increasing demand on the service. There were relatively few ambulance handover delays but at busy times, some patients queued on ambulance trolleys in the department and this impacted on their comfort, privacy and dignity.

The ED worked well with the patient flow team and the rest of the hospital to minimise blockages and overcrowding in ED. The trust had invited an external review of patient flow by the emergency intensive support team (ECIST) and had developed an improvement plan based on their

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recommendations and had taken some immediate actions, although some changes required time to embed. Further improvements were planned but required time and resource.

The service had not developed a clear vision or a cohesive strategy. Although the service had responded appropriately to recommendations made by an external reviewing body and there were ongoing staffing reviews, these were largely reactive plans and did not form part of an overarching strategy. Staff had not been involved or engaged in developing a vision or strategy and there was limited evidence of patient involvement.

Risks to service delivery were understood by the management team but risk management processes were not fully effective. The risk register did not capture the multi-factorial risks to patient safety and quality and we could not be assured that risks were appropriately escalated or mitigated.

Staff enjoyed working in this service and the culture was one of mutual respect and teamwork. Staff felt supported and valued by senior managers who were both visible and accessible. However, morale was overshadowed by issues relating to staffing. Staff had little confidence that these issues would be resolved in the short term and there was a risk that these issues may in the future, impact on recruitment and retention of staff.

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

Good



We rated medical services as good overall. Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them. Learning from incidents was evident and care and treatment within the hospital protected patients from avoidable harm.. Medical cover, nursing levels and skill mix were appropriate to the needs of the patients on the eight medical wards we visited, which included the acute medical assessment unit, the endoscopy suite and the cardiac catheter laboratories. We did however identify a breach in regulation in relation to record keeping, and specifically to the documentation of cannulas, catheters and patients' weight.

Care was effective and was delivered in accordance with evidenced-based guidelines and current best

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practice. Staff managed patients' pain well and feedback from patients reflected this. The trust ensured staff were adequately trained and competent to carry out their role.

Staff provided compassionate care and patients were treated with kindness, dignity and respect. Patients spoke positively about their experience of being cared for at Salisbury hospital. They felt included in their care and were kept informed about their care and treatment throughout their stay.

The provider planned services and coordinated care well for patients living with dementia. The layout and appearance of wards provided a suitable environment for these patients. Patients accessed care and treatment in a timely way.

Services were not always responsive to patients' needs and required improvement. The provider could not always assure adequate patient flow within the hospital. This meant that mixed-sex accommodation breaches frequently occurred and patients were moved during their stay, sometimes late at night. The hospital could not always provide a bed for care and treatment of medical patients on a medical ward. These patients were called medical outliers and were admitted to surgical wards.

However, staff and patients were always aware of which doctors were providing specialist medical care and treatment to them and nursing staff were competent to deliver their care.

The medical services were well led. Staff were aware of the hospital's vision and values spoke of the family atmosphere of working in the hospital. The leadership, governance and culture promoted the delivery of high quality care. There was a clear set of values driven by quality and safety and staff were familiar with these. The trust engaged its patients and visitors regularly to obtain feedback in order to improve the patients' experience in the hospital. Staff spoke highly of their managers and felt their views and concerns were listened to and acted upon. The staff survey showed staff recommended the hospital as a place to work.

## Surgery

### Requires improvement



As the hospital recognised, nursing and operating-department practitioner staffing levels were not always satisfactory. In some wards the

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established levels of nursing care provided at night were not following recommended guidance and unsafe. The workloads from high levels of agency staff at times were causing some staff stress and anxiety. Patients praised the care but a number felt reluctant to call for support due to a perception of nurses and nursing assistants being too busy. Safety in operating theatres was good but some improvements were needed in assurance and culture. Problems with surgical instrument sets needed resolution. Reviews of deaths in the hospital needed to be improved to show learning and improvement happened. Security of patient charts needed to be improved as some were not being kept confidential. Staff mandatory training updates was not meeting trust targets.

The hospital was clean and infection prevention and control protocols followed. Incidents and near misses were being well reported and investigated. There was a safe level of cover from the medical staff and deteriorating patients were recognised and responded to.

Length of stay in the hospital was mostly better than the England average. Patients' pain, nutrition and hydration were well managed with specialist input when needed. Staff were skilled and experienced, although not all had received an annual performance review. There was strong multidisciplinary input to patient care. Important services were provided seven days a week and there was good access to information. The majority of audits showed patients were getting good outcomes, but some audit results needed more attention where they were not being used to demonstrate change, learning or improvement. Feedback from patients and their families had been almost entirely positive overall and several patients described their care to us as outstanding. The Friends and Family Test produced excellent results. Patients we met in the wards and other units spoke highly of the kindness and caring of all staff, although not without mentioning how busy they were. Staff ensured patients experienced compassionate care, and worked hard to promote their dignity and human rights.

The hospital had not resolved the conflict between meeting targets for patients to have treatment and

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putting undue pressure on services to perform. There were many aspects of good responsiveness, but pressure for beds was leading to too many patients being inappropriately discharged from the main theatres or day-surgery unit. As with most NHS hospitals, this hospital was regularly faced with a high number of patients who were fit for discharge, but without transfer of care packages. Patients were complimentary about the food. There was a wide-range of leaflets and information for patients and people with additional needs were being looked after. Cancelled operations were low, and the pre-admission, admission and discharge services provided good support. The surgery service had an effective governance process, although some areas needed to be improved to show a consistent approach. There was good leadership and local-level support for staff. All the staff we met showed commitment to their patients, their responsibilities and one another. There was a strong camaraderie within teams. We were impressed with the loyalty and attitude of the staff we met. Staff were recognised by the trust for their commitment, professionalism and going the extra mile for the patient.

## Critical care

### Requires improvement



Critical care services required improvement to be safe and well led. We found the service good for caring, effective and responsive. Policies and procedures to prevent patients from the risk of healthcare associated infections were not consistently adhered to. The use of personal protective equipment was inconsistent by bedside nursing staff during the inspection. A commode was found to be dirty and a standard cleaning procedure for cleaning the commodes was not available on the unit. There were occasions when nurse staffing numbers did not meet recommended staffing ratios. Medical staffing was found to be in line with core standards for intensive care services. There was sufficient equipment to provide critical care and respond to emergencies. However, the resuscitation trolley log was not consistently signed

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to indicate that it had been checked and was ready for use. The bed spaces did not comply with best practice guidelines for critical care facilities regarding accessibility and space.

Incidents were reported and appropriate actions were taken to attempt to prevent recurrence. However, mortality and morbidity meetings had commenced recently and therefore could not provide assurance of any improvements or actions taken.

Overall, staff were aware of their responsibilities to report abuse and how to raise concerns about safety. Some online mandatory training rates for trained nurses were lower than the trust target of 85% and mandatory training compliance data for unit based staff was not supplied, which meant there was a risk that staff were not up-to-date with current practice.

Records and medicines were found to be stored and managed securely. However, documentation in the healthcare records and charts was not always complete or timely.

Patients' needs were comprehensively assessed and care and treatment regularly reviewed on the unit. Information about care and treatment and patients outcomes was routinely collected and monitored. Local and national audits were taking place and results were being used to improve care, treatment and patients' outcomes. Staff could access the information they needed in order to deliver effective care. Patients care and treatment was planned and delivered in line with current evidence based guidance, particular focus was given to rehabilitation. However, we found that there were some guidance and policies on the unit that were out of date. In addition, documentation of patients' pain scores could be improved.

There was input into patients care from relevant members of the multidisciplinary team in order to provide effective treatment plans. However, the pharmacist did not attend consultant led ward rounds as recommended in the guidelines for the provision of intensive care services (GPICS 2015). Staff were qualified and had the skills to carry out roles effectively in critical care. This included competencies in blood transfusion and intravenous therapy administration. However, half of the

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nursing staff had not received an appraisal in the last twelve months, order to identify learning needs. In addition, training in the use of equipment on the unit required further improvement for both medical and nursing staff.

Discharge from the unit was planned and included follow up services after going home from hospital, to support patients post critical illness.

Patients we spoke with were positive about the care they had received. Many kind and caring interactions were seen during the inspection. Staff were seen to maintain a high regard for patient's dignity and privacy.

Relatives expressed that they had been kept up to date with their loved ones progress and supported by the staff at the bedside. Not all relatives had received timely communication; one family had not been updated by medical staff. However, this was not a consistent finding amongst all relatives and visitors, and the majority were very happy with the level of emotional care and treatment they and their loved ones had received.

The support continued following discharge home from hospital via the follow up team that supported patients after critical illness. The follow up clinic that the team provided had recently held a reunion event which had been well attended.

Aspects of the refurbishment and design of the unit had been made in collaboration with staff and local people. The facilities for relatives had been improved with a thoughtful inclusion of secure storage of valuables in the waiting area. However, not all bed spaces were capable of giving reasonable auditory privacy. There were no toilet or shower facilities for patients within the unit. However, patients were able to access these facilities in a neighbouring ward without entering a general public area.

There were delayed patient discharges due to a bed elsewhere in the hospital not being available.

Similar to most critical care units in England, in the last five years between 60% and 70% of all discharges were delayed by more than four hours from the patient being deemed ready to leave the unit.

Urgent surgical operations had been cancelled due to the lack of an available bed in critical care. This



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was above (worse than) the national average. Figures from NHS England reported 53 cancelled operations at the hospital between July and December 2015. We found that there was no limit per day for how many beds could be booked on the unit for those patients that require critical care after elective operations.

Despite the pressures on bed availability, patients were admitted to the unit in a timely fashion and the unit had not transferred patients to other units for non-clinical reasons for over twelve months. Data from the Intensive Care National Audit and Research Centre (ICNARC) showed that the unit transferred less patients to the wards out of hours than the England average (performed better).

Arrangements for governance of critical care services did not always operate effectively. For example, the risk register did not include risks that staff highlighted during the inspection and the risks had not been reviewed and updated. The governance structure and processes seemed immature and not embedded. In addition, it was not always clear how the local governance linked with formal trust wide processes. This meant that there was a risk that issues that required escalation were not being raised formally.

Following the refurbishment and recent changes in leadership of both nursing and consultant leads, the team appeared to be in a period of adjustment. The team culture was strong within the unit. However, opportunities for staff engagement could be improved, for example unit meetings had been abandoned due to poor attendance.

## Maternity and gynaecology

Good



Care in both the gynaecology and maternity wards and delivery suite was consultant led. Patients had risk assessments completed and reviewed regularly. Incidents were reported and thoroughly interrogated for learning and safety improvements. Good safeguarding processes were in place, which included established links with the lead local authority. Staff demonstrated understanding of duty of candour regulations and compliance with this was also evidenced in records. Safety improvements were required to the maternity services. The midwifery staffing levels did not comply with the Health and Social Care Act

# Summary of findings

(2008) Code of Practice on staffing. The midwife to patient ratio exceeded (was worse than) recommended levels and one to one care for women in established labour was not evidenced to have been achieved 100% of the time.

The maternity services were responsive to the needs of local women. Positive feedback was consistently provided. This showed the majority of patients were highly satisfied with their treatment and care and would recommend services. We saw records documenting patient's choices and preferences. The maternity services had achieved full accreditation with UNICEF UK breast feeding standards. The gynaecology service had links with other specialists and treatment centres. This supported the provision of effective care and treatment plans for patients. Annual audit plans were in place which enabled clinical standards of practice to be checked and improvements made. Policies and procedures were provided in line with national guidance and policy.

There were thorough risk management and quality and governance structures in place. These linked departmental with trust risk and governance meetings. This ensured an effective flow of information from ward to board and vice versa. Incidents, audits and other risk and quality measures were scrutinised for service improvements and appropriate actions taken. Systems were in place to effectively share information and learning. Staff were proud of the patient care they provided and a learning culture was evident. Leadership was described as good. Junior staff told us they were well supported and senior managers were visible and approachable. The trust board had approved a capital investment in the maternity services. This included the provision of a new midwifery led birth unit.

## Services for children and young people

### Requires improvement



Overall we found the services for children and young people to require improvement. Staff were clear they wanted to provide the best care they could for children and young people but there was no clear vision for how the service wanted to be performing in the coming years. Staffing levels for both medical and nursing staff did not meet the nationally recommended guidelines

## Summary of findings

for the acuity of children cared for in the hospital. Risks to patient safety regarding nurse staffing levels had been raised as a concern but no permanent arrangement had been put into place to maintain safe staffing levels. High dependency patients were nursed on the ward but there was no funding available for the extra nursing staff needed to care for these patients.

Safeguarding training did not meet national guidelines at the time of our visit but we were shown a plan was in place to provide this training and a timeline for meeting the guidelines.

There were times when children and young people were cared for in areas used for adults such as some outpatient appointments, main theatre and day surgery unit. Some provision had been made to protect children from adults in these shared areas. We found the screens to protect a child were not always used.

Learning from examples of past practice was encouraged and medical staff felt well supported by their senior colleagues. Staff were able to access training that would add to their skills and the majority of nurses in the neonatal unit were trained in their specialty. Children and young people's needs were cared for and responded to by competent staff. Policies and protocols were based on national guidelines ensuring that best practise was observed. Audit programmes were contributed to both internally and nationally to demonstrate how well the department performed against other trusts.

All staff worked flexibly to support the needs of children, young people and their families. Staff worked together and shared information appropriately with community staff to ensure the safety and wellbeing of children who were being discharged home.

Staff were compassionate in their treatment of patients and their families and privacy and dignity was respected at all times. Children and young people's views were listened to and their consent was always sought in a way they could understand. Facilities were provided and used flexibly for parents to spend time with their children and at times included the accommodation for the patient's whole family.

# Summary of findings

Staff had developed methods of gaining feedback from children of all ages and had made changes to facilities in response. Patient and parent feedback we saw was positive with comments including “unconditional support and care”, “cheerful, even at the end of a long shift” and “patience and honesty”. Staff from the children’s unit were supporting those areas where adults were also nursed with projects designed to improve a child or young person’s experience when they visited that area.

## End of life care

Good



We have judged the overall end of life service as being good.

The trust could organise rapid discharges effectively but there were delays due to funding of care packages in the community. The trust had not recently completed an audit of patients achieving their preferred place of dying.

There was an improvement plan in place for end of life care that was being overseen by a strategy steering group. There had been a number of changes put into place in the previous twelve months. These were initiated following the results of the National Care of the Dying Audit that was completed in 2014 and also to respond and implement national directives such as the NICE Quality Standard on End of Life Care. These included a new personalised care framework, to replace the discontinued Liverpool Care Pathway, improved rapid discharge processes and the appointment of two end of life care facilitators to roll out the new documentation and provide training. Whilst some of the changes were not fully imbedded the staff were committed and motivated to provide an improving service and embraced the initiatives that were being developed by the end of life steering group.

There was evidence of leadership in both the palliative care team and at board level however despite the work undertaken to deliver the improvement plan there was no trust wide strategy or policy on end of life care. This was combined with limited representation at the strategy steering group from board members.

## Summary of findings

Staff understood their responsibilities to raise and report concerns, incidents and near misses. They were clear about how to report incidents and we saw evidence that learning was shared across the teams.

Equipment was readily available and properly maintained for the use of patients. Anticipatory medicines were always available and patients being discharged home had their medicines provided promptly.

There were processes in place to assess and respond to patient risk. Staff were able to contact members of the palliative care team for advice about deteriorating patients and this team was responsive and supportive to urgent requests for input. The palliative care team were staffed sufficiently to provide the advice and support that was requested.

The trust was providing a seven day service from members of the palliative care team but this was only currently being funded until the end of March 2016.

There was a range of training that was provided for members of the palliative care team and also training that was available to other staff if they could be released from their duties but there was currently no mandatory end of life training for staff trust wide.

Patients received compassionate care and were treated with respect and dignity by staff. Patients were communicated with sensitively and kept informed about their diagnosis and prognosis. Staff worked in a positive and open culture and felt supported by their colleagues and line managers. Staff felt valued by the trust and were engaged with the trust objectives.

The end of life service rated poorly in the 2014 National Care of the Dying survey. New paperwork and processes were being introduced and every member of staff on every ward was receiving a two-week training package in end of life care. There were no audits to evidence how the service was achieving rapid discharge or if patients were supported with their preferred place of care. The leadership needed to develop a trust wide strategy and policy for end of life care.

# Summary of findings

## Outpatients and diagnostic imaging

Good



Salisbury NHS Foundation Trust outpatient and diagnostic services were overall rated as good. There were good systems in place for incident reporting and learning from when things did not go as planned. Systems were in place for the safe administration of medicines and for the prevention of infection. The outpatient and medical records department achieved a high standard in making sure medical notes were available for 99.91% of appointments. Staff were knowledgeable about safeguarding and their responsibilities to vulnerable adults and children. During our inspection we observed an emergency situation in the outpatients department. The way in which this was handled showed staff were aware of the health of their patients and responded quickly and appropriately to any deterioration in a patient's health.

Staff were very competent in the roles they were being asked to perform. There were some outstanding areas of practice including the nurse led pathways within the rheumatology outpatients clinics and one stop clinics within urology outpatients. There was good multidisciplinary working both within the trust and with other external organisation such as other health care providers and the Ministry of Defence.

Staff communicated in a professional but friendly manner with patients and their families. Comments from patients and relatives were very positive about the staff and how they provided their care and treatment. Patients were involved in their care and treatment and always put them first.

The departments provided a good service to make sure people were not waiting long periods of time for either outpatients or diagnostic services. The trust was working with other local hospitals and looking at capacity demand in order to make sure waiting lists did not increase. We saw that the trust was achieving 92.94% for its cancer two week waiting time against a standard of 93%. Outpatients departments operated a 'patient initiated follow-up' appointment which meant for a three month period patients could arrange a follow-up appointment if they felt they needed it. We saw

# Summary of findings

evidence that complaints were discussed at departmental meetings and changes were made where necessary to help prevent further complaints.

Staff were supported at all levels from their immediate manager through to the trust executive team including the chief executive. Good governance systems were in place across outpatients and diagnostics. Whilst some staff described the culture as a 'them and us' we did not see this view shared by the majority of staff. The majority of staff we spoke with felt the culture was open and that staff strived to make sure the experience for patients was outstanding in line with the trust vision.

**Spinal  
injuries  
centre**

**Requires improvement**



# Salisbury District Hospital

## Detailed findings

### Services we looked at

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



# Detailed findings

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### Detailed findings from this inspection

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## Background to Salisbury District Hospital

Salisbury NHS Foundation Trust provides care to over 240,000 people across Wiltshire, Dorset and Hampshire. This includes general and acute services at Salisbury District Hospital with specialist services including burns, plastics, cleft lip and palate, genetics and rehabilitation serving over three million people. In addition the Duke of Cornwall Spinal Treatment Centre serves South England's population of 11 million people.

We inspected this trust as part of our programme of comprehensive inspections of acute trusts. The inspection team inspected eight core services as well as an additional service, the spinal service:

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

## Our inspection team

Our inspection team was led by:

Chair: Julie Blumgart; former Clinical Quality Director, South region.

Head of Hospital Inspections: Mary Cridge, Care Quality Commission

The team included CQC inspectors and a variety of specialists: two directors of nursing, lead for safeguarding adults and children, registrar in emergency medicine, senior sister in emergency medicine, matron in trauma

and orthopaedics, consultant anaesthetist, critical care nurse, consultant in paediatric palliative medicine, ward sister, deputy medical director - consultant obstetrician and gynaecologist, head of midwifery, consultant physician, clinical nurse specialist, consultant radiologist, nurse, consultant neonatologist, senior manager for paediatrics and child health, consultant general surgeon and medical director, surgical nurse, specialist registrar, ST3 in immunology. The team also included two experts by experience, analysts and an inspection planner.

# Detailed findings

## How we carried out this inspection

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about Salisbury Hospital. These included the local commissioning groups, Monitor, the local council, Wiltshire Healthwatch, the General Medical Council, the Nursing and Midwifery Council and the Royal Colleges.

We held two listening events in Salisbury on the 3 and 19 November 2015. More than 59 people attended the events. People who were unable to attend the event shared their experiences by email and telephone and on our website.

We carried out an announced inspection on 1, 2, 3 and 4 December 2015 and an unannounced inspection on 13

December 2015. We held focus groups and drop-in sessions with a range of staff in Salisbury Hospital, including nurses, junior doctors, consultants, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff, porters and maintenance staff. We also spoke with staff individually as requested.

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

## Facts and data about Salisbury District Hospital

Salisbury Hospital has 464 beds and is staffed by approximately 4054 members of staff. They provide care to around 240,000 people across Wiltshire, Dorset and Hampshire.

In 2014/15, the trust had 6,405 elective inpatient admissions and 28,494 emergency admissions. There were 183,732 outpatient attendances, along with 43,998 attendances at accident and emergency. It had revenue of £355,014k, the full cost was £355,593k therefore there was a financial deficit of £579,000. This was the first year in its history Salisbury NHS Foundation Trust had reported a deficit.

Overall the bed occupancy at the trust has been below the national average (85.9%) apart from in the fourth quarters of both 2013/14 and 2014/15. It is generally accepted that bed occupancy over 85% is the level at which it can start to affect the quality of care provided to patients and the orderly running of the hospital.

Salisbury NHS Foundation Trust has fairly stable executive and non-executive team. The chairman has been in post for one year supported by a board of non-executive directors with a range of skills and expertise, two of whom have been in post for seven years. The chief executive has been in post for two years having worked in the trust since 1986. The director of nursing

and chief operating officer are the newest recruits to the board at one year and six months respectively, with other members of the executive team having been in post three to five years, except for the director of finance and procurement who had been in post for 29 years.

### CQC Inspection History

Salisbury District Hospital has had three inspections since 2011. The first inspection carried out in May 2011 found that Salisbury District Hospital was meeting all the essential standards of quality and safety, but to maintain this we suggested that some improvements were made in reducing the incidences of pressure ulcers, appropriate use of bed rails, timely support for patients, record keeping and cleanliness of some public areas.

Another inspection was carried out in February 2013 and standards were not met in staffing and the keeping of records. Concerns were raised that staff did not have sufficient qualifications, skill or expertise to meet the people's needs effectively at all times. Concerns were also raised that paper-based confidential patient information was not being protected effectively on certain wards. A further inspection was carried out in October 2013 to review whether improvements had been made found that sufficient improvement had been made by the trust in these areas.

# Detailed findings

## Our ratings for this hospital







Our ratings for this hospital are:

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

### Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

# Urgent and emergency services

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

## Information about the service

Urgent and emergency care and treatment is provided at Salisbury District Hospital (SDH) by the medical directorate. The emergency department (ED), otherwise known as the accident and emergency department, operates 24 hours a day, seven days a week. The ED saw approximately 44,400 patients in 2014/15 of whom around 20% were children. Some expected patients referred by their GPs are admitted via the ED. However the ED is not the only point of urgent access to the hospital, with some expected urgent cases being admitted directly to the acute medical assessment unit (AMAU), the surgical assessment unit (SAU) and the children's ward, Sarum.

Adult ED patients receive care and treatment in two main areas; minors and majors. Self-presenting patients with minor injuries are assessed and treated in the minors area. This area is open from 8am until midnight. Some patients are streamed to see the co-located out-of-hours GP. Patients with serious injuries or illnesses who arrive by ambulance are seen and treated in the majors area, which includes a three-bay resuscitation room. The majors area is accessed by a dedicated ambulance entrance.

There is a separate children's unit; however this was not in use at the time of our visit because it could not be adequately staffed. Although the dedicated children's waiting room was in use, children were assessed and treated in the adults' department.

The ED is designated a trauma unit and provides care for all but the most severely injured trauma patients. Severely injured trauma patients are usually taken by ambulance to

a major trauma centre if their condition allows them to travel directly. They are otherwise stabilised at SDH and either treated or transferred as their condition dictates. There is a helipad located close to the hospital site from which patients are transferred to the ED by road ambulance.

There is a short stay emergency unit (SSEU) located adjacent to the ED and staffed and managed by the ED. This is an eight-bed observation ward that allows for further assessment of patients who are likely to remain in the unit for between four and 24 hours, or in the case of a head injury, 48 hours, but are not likely to require admission. The unit is also used to accommodate patients who require admission to a specialty bed but none are available.

We visited the ED over two and a half weekdays and we did an unannounced inspection at the weekend. We spoke with approximately 30 patients/relatives. We spoke with staff, including nurses, doctors, managers, therapists, support staff and ambulance staff. We observed care and treatment and looked at care records. We received information from our listening events and from people who contacted us to tell us about their experiences. Prior to and following our inspection, we reviewed performance information about the trust and information from the trust.

# Urgent and emergency services

## Summary of findings

The emergency department (ED) was not consistently staffed by sufficient numbers of appropriately qualified, experienced and skilled nursing staff to ensure that people received safe care and treatment at all times. The nursing establishment did not ensure that an appropriate ratio of nursing staff to patients was consistently achieved. This was compounded by the fact the service had a significant numbers of nursing staff vacancies and relied heavily on temporary staff who did not always have the necessary skills and experience to provide safe and effective care.

Staffing levels at night were of particular concern and there were concerns about the lack of seniority of medical and nursing staff on duty at night. We had concerns that there were insufficient registered children's nurses employed and there was a lack of assurance that this risk had been mitigated by ensuring that adult trained nurses had received specialist training to care for children. As a result of this lack of appropriately skilled staff, the separate children's area was not being used because it could not be adequately staffed. Children instead received care and treatment in the adults' department which was not an appropriate environment.

Staffing issues impacted on the department's ability to ensure that patients were consistently promptly clinically assessed on arrival in the ED. We were particularly concerned about the delayed clinical assessment of self-presenting patients (adults and children) who were not adequately observed while they waited. We also had concerns that nursing documentation was not always completed to the required standard. Staff shortages may also have affected staff's ability to complete mandatory training. Compliance with mandatory training was well below the trust's target of 85%. We were not assured that nursing staff had sufficient opportunities for ongoing education and development or clinical supervision.

People's care and treatment was planned and delivered in line with current evidence-based guidance and standards. We saw good levels of compliance with recognised care pathways, including those for sepsis and stroke care. Compliance with protocols and

standards was monitored through participation in national and local audits. Performance in national audits was generally about average compared with other English trusts, with the exception of the Royal College of Emergency Medicine mental health audit, where performance required improvement. There were action plans in place to make improvements where shortfalls were identified. We saw little evidence of local audit.

The trust's un-planned re-attendance rate was consistently lower (better than) the England average. This was an indicator that care and communication with patients were effective.

Junior doctors felt well supported with regular education and supervision. The lack of senior medical presence in the ED was to some extent mitigated by senior review of all records of patients seen overnight.

The service worked well with other teams and services so that people received seamless care. Care was delivered in a coordinated way, with support from specialist teams and services. There were excellent working arrangements with the Acute Medical Unit, which worked closely with the ED as part of the 'front door team'. There were clear policies agreed with specialty doctors which formalised their supportive role to ED and reciprocal support was offered by ED consultants to junior doctors in other specialties.

We observed that all staff treated people with compassion, kindness, dignity and respect. They responded in a caring and compassionate way when people experienced pain, discomfort or distress. Patients and their relatives were involved as partners in their care. Staff took the time to explain to patients and their relatives about their care and treatment. This was done sensitively and in a way that people could understand. The department had established an outstanding service to support bereaved relatives.

Feedback we received from patients and visitors was overwhelmingly positive. We spoke with many patients and visitors. Unusually, we were approached by some patients who were very keen to tell us how well they had been looked after. This feedback was consistent with

# Urgent and emergency services

results from patient satisfaction surveys. Friends and family scores were consistently high, with over 90% of respondents indicating that they would recommend the service.

Services were not always responsive to people's needs, organised and delivered so that all patients received the right treatment at the right time. Children did not always receive care and treatment in an appropriate environment and patients with mental health needs, including children and adolescents, sometimes waited too long to be assessed by a mental health practitioner. At busy times patients queued on trolleys in the emergency department corridor and this impacted on their comfort, privacy and dignity.

Premises and facilities were largely appropriate for the services delivered; however children were cared for in the adults' department which was not an appropriate environment for them because they were exposed to sights and noise which may cause them stress. The children's waiting room, whilst bright and welcoming, was overlooked by and could be accessed by adult patients and visitors. Patients' privacy and dignity was sometimes compromised on the short stay emergency unit. The ward was cramped and the layout did not always allow for single sex accommodation to be provided.

The needs of patients in vulnerable circumstances were not always met. Patients with mental health needs, particularly children and adolescents, who required assessment by a mental health practitioner, did not always receive a responsive service. This meant that these patients experienced long waits which could be detrimental to their mental health and they were sometimes admitted to hospital unnecessarily.

The department had not taken adequate steps to support patients in vulnerable circumstances, such as those living with dementia.

The ED was consistently meeting national standards in respect of the time people spent in the department, and the time they waited for treatment, although this was becoming more challenging with increasing demand on

the service. There were relatively few ambulance handover delays but at busy times, some patients queued on ambulance trolleys in the department and this impacted on their comfort, privacy and dignity.

The ED worked well with the patient flow team and the rest of the hospital to minimise blockages and overcrowding in ED. The trust had invited an external review of patient flow by the emergency intensive support team (ECIST) and had developed an improvement plan based on their recommendations and had taken some immediate actions, although some changes required time to embed. Further improvements were planned but required time and resource.

The service had not developed a clear vision or a set of values which staff were engaged with. There was a strategy which set out a five year plan in respect of staffing, cohesive strategy. Although the service had responded appropriately to recommendations made by an external reviewing body and there were ongoing staffing reviews, these were largely reactive plans and did not form part of an overarching strategy. Staff had not been involved or engaged in developing a vision or strategy and there was limited evidence of patient involvement.

Risks to service delivery were understood by the management team but risk management processes were not fully effective. The risk register did not capture the multi-factorial risks to patient safety and quality and we could not be assured that risks were appropriately escalated or mitigated.

Staff enjoyed working in this service and the culture was one of mutual respect and teamwork. Staff felt supported and valued by senior managers who were both visible and accessible. However, morale was overshadowed by issues relating to staffing. Staff had little confidence that these issues would be resolved in the short term and there was a risk that these issues may in the future, impact on recruitment and retention of staff.



# Urgent and emergency services

## Are urgent and emergency services safe?

Requires improvement



The emergency department (ED) was not consistently staffed with appropriate numbers of suitably skilled and experienced staff to ensure that patients received safe care and treatment at all times.

The nursing establishment fell short of the nurse to patient ratio recommended by the National Institute for Health and Care Excellence (NICE) and this was overwhelmingly the biggest area of concern raised by nurses and doctors during our visit. Notwithstanding the nursing establishment, the ED had a significant number of nurse staff vacancies and absences which meant the department relied heavily on temporary staff. We could not be assured that temporary staff were appropriately skilled and experienced to provide safe care in ED.

Staffing levels at night were of particular concern, with the nurse to patient ratio sometimes as low as one nurse to ten patients in majors. Staff regularly missed their breaks, and were at risk of fatigue. Medical staffing at night was also a concern, with only junior medical staff on duty from midnight onwards, albeit with a well established support system from the wider hospital medical staff and ED consultants, who were resident when on call.

There were insufficient numbers of registered children's nurses employed to ensure that there was always a children's nurse on duty and the trust could not assure us that they had adequately mitigated this risk through staff training.

We judged that staffing levels and the frequent use of temporary staff may have impacted on other areas of practice, resulting in unsafe or potentially unsafe practice. Patients did not consistently receive prompt initial clinical assessment to ensure that those patients with serious and life threatening conditions could be prioritised. Waiting patients, including children, were not adequately observed.

Nursing documentation, particularly on the short stay emergency unit (SSEU), was generally poor.

A significant proportion of staff were not up-to-date with mandatory training. This meant we could not be assured of their knowledge of safe systems, processes and practices.

Despite these areas of concern, the department had a good track record on safety, with no recent serious incidents reported. Staff were encouraged to report incidents and they received feedback when they raised concerns.

## Incidents

- There were no serious incidents reported in the emergency department (ED) between August 2014 and August 2015.
- Staff told us they were encouraged to report incidents and they received feedback when they did so. Important information following incidents was disseminated at handover meetings, via a communication book or by email.
- There were quarterly mortality and morbidity meetings where the care of patients who had complications or unexpected outcomes was reviewed so that learning could be identified and shared.
- Staff were familiar with their responsibilities under the Duty of Candour regulation. However, we were not provided with any examples of disclosure so we could not be assured that the regulations were complied with.
- Safety thermometer data (data collected on a single day in each month and used to record patient harms) for the period August 2014 to July 2015 showed:
  - There were three no pressure ulcers reported
  - There were no seven falls reported
  - There were no one catheter acquired urinary tract infections reported

## Cleanliness, infection control and hygiene

- In CQC's 2014 A&E survey the trust scored nine out of 10 in response to the question which asked patients whether the ED was clean.
- The department was tidy and mostly visibly clean. However, we found items of equipment in the resuscitation area which were dusty. A patient commented to us that the heart monitor used in their care was dusty.
- Cleaning staff were not available overnight. Nursing staff told us that if an area became contaminated and a

# Urgent and emergency services

specialist or deep clean was required during the night they would have to undertake this themselves (although they were not trained to do so) or take the affected area out of use until the following day.

- There were monthly audits of hand hygiene and compliance with the uniform policy including the bare below the elbow policy. Hand hygiene audits in September and October 2015 showed some room for improvement.
- There were sufficient appropriately sited hand wash basins and hand gel dispensers. We saw that most staff regularly washed their hands and observed standard infection control precautions. However we saw one nurse did not wash their hands or use hand gel in between patients. StaffMost staff observed the 'bare below the elbow' policy.y, although on occasions we saw staff (particularly night staff) wearing long sleeved sweatshirts. We observed a nurse being reminded to tie their hair back at a morning handover meeting. The senior nurse told us that compliance with hygiene standards was checked at every handover meeting.
- Staff wore appropriate protective clothing (gloves and aprons). However, we saw a nurse enter the sluice to dispose of waste and they were still wearing their protective gloves when they came out of this areaThis increased the risk of cross contamination.
- There were two private assessment/treatment rooms in ED majors where infectious patients could be isolated.

## Environment and equipment

- The design, maintenance and use of the ED were mostly appropriate to keep protect people from avoidable harm.
- A patient-led assessment of the care environment (PLACE) was undertaken ED in September 2015. The assessment looked at the safety, suitability and cleanliness of the environment. No major issues were identified.
- In terms of layout the ED was being used well. The centrally located work station in ED allowed medical and nursing staff to observe patients in the department.
- There was a separate waiting room for children, which was adjacent to the adults' waiting area. This was overlooked by, and could be accessed by adults in the

main waiting area. There were restricted lines of sight to the children's waiting area. The area could only be partially viewed by receptionists. The Royal College of Emergency Medicine (RCEM) recommends in its Triage Position Statement 2011 that in the triage environment, consideration should be given to visualisation of the waiting environment. Health Building Note (HBN) 15-01 states "the (ED) waiting area should be provided to maintain observation by staff but not allow patients or visitors within the adult area to view the waiting area."

- The department was well equipped. However, some equipment was not appropriately stored. In the entrance to the ED there were a number of wheelchairs stored. On one day of our inspection these were stored two deep in an untidy fashion and there was a risk that patients and visitors may knock their legs on these and sustain an injury.
- Consumable items were in plentiful supply and were appropriately stored. However, we found chlorine granules (a hazardous substance) stored in an unlocked cupboard in the sluice.
- We checked a range of equipment, including resuscitation equipment. It was accessible, mostly clean and well maintained. Regular equipment checks took place; however, on the SSEU there were no records available to show that the crash trolley had been checked on 1 and 2 December 2015. In the resuscitation area we found a syringe pump which was overdue for service.

## Medicines (includes medical gases and contrast media)

- Medicines were appropriately stored in locked cupboards or fridges. Fridge temperatures regularly checked and they were they correct at the time of our visit.
- Controlled drugs were appropriately stored and suitable records were kept. Controlled drugs are medicines which require extra checks and special storage arrangements because of their potential for misuse.
- We found a box of mixed intravenous fluids stored in the resuscitation area. This increased the risk that staff may not identify the correct fluid in an emergency situation.
- In CQC's 2014 A&E survey the trust scored 9.2 out of 10 in response to the question which asked patients whether



# Urgent and emergency services

that the purpose of new medicines was explained before they left A&E. However, the trust scored only 5.3 out of 10 in response to the question that asked patients whether they were told about possible side effects of medicines for those prescribed new medicines while in A&E.

- Some Emergency Nurse Practitioners (ENPS) were trained as non-medical prescribers so that they could supply and administer certain medicines. There were also Patient Group Directions (PGDs) in place. PGDs are agreements which allow some registered nurses to supply or administer certain medicines to a pre-defined group of patients without them having to see a doctor. We saw evidence that PGDs were up-to date or identified as being under review.

## Records

- Patients' records were accessible. In ED the need for accessibility outweighed the need for security but we were satisfied that patients' records were not easily accessible to people who were not authorised to view them. In the SSEU patients' records were stored on the top of the nurses' station which made them easily accessible to unauthorised people.
- We looked at a sample of patient records. Nursing documentation was generally poor. Although regular observations were consistently recorded, other nursing care was not well documented and entries were frequently not dated and timed.
- We found documentation on the SSEU to be particularly poor. In one patient record we found scanned notes relating to two other patients. The nursing assessment documentation did not have addressograph labels affixed to every page, which meant there was a risk that patients' records may be mixed up. Two sets of records were maintained for each patient. One set related to their attendance in ED and the other to their admission to SSEU. Entries by nursing staff to document the care given to patients whilst on the SSEU were brief and infrequent, and were sometimes recorded in the wrong set of notes, making it difficult for continuity of care to be assured. A nurse told us that agency staff were frequently employed on this unit and may be unfamiliar with the paperwork.

- The ED participated in an annual records audit, the last one of which took place in late 2014 and showed good levels of compliance with record keeping standards.

## Safeguarding

- Staff understood their responsibilities in respect of safeguarding vulnerable adults and children and were aware of safeguarding policies and procedures. Two consultants and two nurses were identified as safeguarding leads., although there was no lead nurse for safeguarding.
- All ED staff were required to complete level 2 safeguarding training as a minimum. This is one of the safeguarding children's standards set by the Royal College of Emergency Medicine (RCEM). Training records showed that only 64% of staff had completed this training. The RCEM also recommends that all senior emergency medicine doctors (ST4 or equivalent and above) should have level 3 child protection training. The trust confirmed that this standard was not met, although training had started in 2015 and was planned to continue in the forthcoming year.
- The ED patient record prompted staff to consider safeguarding in their assessment of each patient. We saw that safeguarding assessments were consistently completed.
- There were processes in place for the identification and management of children at risk of abuse:
  - The patient record system identified previous child attendances in the last 12 months so that staff would be alerted to possible safeguarding issues.
  - Frequent attenders were discussed with the paediatric team.
  - There was access to a senior paediatric opinion 24 hours a day for child welfare issues.
  - All skull or long bone fractures in children under one year were discussed with a senior paediatric or ED doctor during their ED attendance.
  - There was a safety net system in place whereby the trust safeguarding lead reviewed all children's ED records and all health visitor referral forms. However, records were only collected weekly; therefore a failure to make a safeguarding referral would not be identified promptly. We identified that a child at risk

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was not identified when they attended the ED in early November 2015. This had not been picked up by the safety net system. We drew this to the attention of the ED senior staff and the trust safeguarding lead and asked them to investigate the system failure. This was still under investigation.

- All child attendances were notified to GPs and to health visitors and school nurses.
- Some staff were familiar with the policy which outlined responsibilities in relation to safeguarding women or children with, or at risk of, female genital mutilation (FGM). Other staff knew where to locate the guidance on the trust's intranet. One nurse we spoke with had no knowledge of any policy or guidance in relation to this.

## Mandatory training

- A significant proportion of staff were not up-to-date with mandatory training. This meant we could not be assured of their knowledge of safe systems, processes and practices. Training records showed mandatory training compliance was well below the trust target of 85% as follows:
  - Equality and diversity: 73%
  - Fire safety: 51%
  - Hand hygiene assessment: 56%
  - Health and safety overview: 71%
  - Infection prevention and control: 64%
  - Information governance: 51%
  - Moving and handling: 52%
  - Safeguarding adults: 78%
  - Safeguarding children level 2: 64%

## Assessing and responding to patient risk

- Patients did not always receive an initial clinical assessment by a healthcare practitioner within 15 minutes of arrival in ED. Guidance issued by the College of Emergency Medicine (Triage Position Statement, April 2011) states that a rapid assessment should be made to identify or rule out life/limb threatening conditions to ensure patient safety. This should be a face-to-face encounter which should occur within 15 minutes of

arrival or registration and assessment should be carried out by a trained clinician. This ensures that patients are streamed or directed to the appropriate part of the department and the appropriate clinician. It also ensures that serious or life threatening conditions are identified or ruled out so that the appropriate care pathway is selected.

- Information displayed on a notice board in the ED stated that during the month of October 2015 the average time patients waited to see an assessment nurse was 23 minutes. During our unannounced visit on a Sunday we observed patients were frequently waiting in excess of 30 minutes, with some self-presenting patients waiting up to an hour.
- The trust used a recognised triage tool (Manchester triage tool), although this and the triage policy were under review at the time of our visit. A streaming protocol had recently been introduced for patients who self-presented at reception. Receptionists had a list of patient conditions/complaints, which were categorised as red, requiring assessment in majors or blue, requiring assessment in minors. Patients who were categorised red would be called through to majors to wait in a cubicle if there was one available. However during our unannounced visit, when the department was busy, they could not be accommodated in majors and continued to wait in the waiting room. We were concerned that there were undifferentiated unwell patients sitting in the waiting room who were not observed by healthcare practitioners. When we raised this concern with a senior nurse they acknowledged that this was a concern. They told us that the triage nurse was responsible for overseeing the waiting room. However, we observed that the triage nurse rarely entered the waiting room and called patients from the door of the assessment cubicle. Receptionists were able to describe serious and life threatening conditions which would prompt them to call for immediate support from a healthcare practitioner. There was a visual alert on the electronic patient record system where reception staff documented concerns, along with the name of the member of staff they had escalated their concerns to.
- A checklist had been developed to help staff prepare for the arrival of a seriously ill/injured patient for which they had received an alert from the ambulance service. This

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ensured that they obtained vital information from the ambulance service and informed the relevant clinicians, for example the stroke team or the trauma team, so that they were on standby.

- We observed a failure to appropriately escalate and request a medical review of a patient who presented with palpitations. The patient was triaged within 15 minutes of arrival and placed on a heart monitor. However, monitor readings indicated the need for an urgent doctor review which should have been requested immediately. This was not requested for a further 40 minutes, at which point the patient was reviewed by a doctor immediately.
- Patients presenting in ED with mental health issues were assessed using a recognised mental health risk assessment. This graded the risk of self-harm or harm to others as red, amber or green. We noted that the risk assessment documentation was not consistently used. Four out of ten patient records we reviewed for patients presenting with mental health issues between 20 October and 3 November 2015 had not had a mental health risk assessment completed. Two of these 10 patients had been assessed as medium to high risk but were discharged without referral to the mental health liaison team. We discussed our concerns with the ED consultant lead for mental health. They acknowledged that there had been a problem regarding documentation of psychiatric referrals. A new proforma had recently been introduced to document discussions with the mental health team and guidance had been issued to junior doctors.
- Staff told us that patients who were assessed as high risk would be cared for in majors so that they could be closely observed, while awaiting an assessment by the mental health team. We saw a documented example of this.
- There was an enhanced nursing risk assessment tool used to assess the need for additional nursing support for patient, including those who had some form of cognitive impairment, learning difficulties or mental health concerns. There was also an intentional rounding tool used to monitor patients who had been identified as being at high risk of falls. We saw this in use for a patient who was living with dementia who was admitted to the SSEU overnight.

- The ED and SSEU used a recognised early warning score tools to assess patients' risk and their need for physical observations. Documentation clearly set out triggers for frequent observations and when to seek senior help. There was similar documentation for infants, pre-school children and children of school age.
- We looked at a sample of observation charts in the ED and the SSEU. They were mostly consistently completed, showing that observations were taking place with the required frequency. However, on the SSEU we noted for one patient that the frequency of observations required was not recorded. The patient was receiving four hourly observations but there was no documented reason to explain why the frequency had reduced from the two hourly observations that had taken place when they were in the ED. When we queried this with the nurse on duty, they told us that the information had been passed on verbally but not recorded.
- Monthly audits of observation charts took place on SSEU. The most recent audit data provided (June 2015) showed that charts were appropriately completed, although one out of five charts reviewed did not have frequency recorded.

## Nursing staffing

- The ED was not consistently staffed with appropriate numbers of suitably skilled and experienced nursing staff to ensure that people received safe care and treatment at all times. Nurse staffing levels was overwhelmingly the biggest area of concern voiced to us by both nursing and medical staff.
- Staffing levels had recently been increased. A review of nurse staffing levels in ED was undertaken by the ED senior nurse in June 2015. Prior to this, there had been no formal review of ED nurse staffing levels for 11 years. The review was undertaken in the context of increasing demand and a department which was described in the review as "struggling to consistently deliver safe, responsive and effective care..." The review took into account the draft 'Safe Levels of Nurse Staffing in the Emergency Department' published in January 2015 by the National Institute for Health and Care Excellence (NICE) and the more recent ECIST review in February 2015. ECIST recommended that there should be a

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review of the seniority and skills mix of nursing staff and with particular attention to the out-of-hours and overnight levels. "There were two recommendations which were considered to be urgent:

- The deployment of a senior nurse to manage each shift. The trust had acted on this recommendation and had employed additional band 6 nurses to manage each shift, although we were told that occasionally a more junior nurse (band 5) may be deployed. Despite this action, a number of consultants expressed the view that some nurses deployed to manage shifts were not sufficiently senior or experienced and there remained a lack of senior decision makers at night. Draft NICE guidance recommends that the senior nurse in charge should be a band 7 nurse. The trust had not followed this guidance because of financial and recruitment constraints.
- An increase in the nurse to patient ratio in the resuscitation area. The trust had acted on this recommendation and increased the staff to patient ratio from 1:3 to 2:3.
- Notwithstanding the above increases in staffing, the current established levels still fell short of staff to patient ratios as recommended by the draft NICE guidelines and continued to cause concern to nursing and medical staff.
- The current nurse staff establishment provided a staff to patient ratio of one registered nurse to five patients in majors, supported by a healthcare assistant. At night this ratio reduced to one to 10. NICE recommends that the minimum staff to patient ratio in majors should be one registered nurse to four patients. This could only be achieved by utilising the second nurse from the resuscitation area or by using the senior nurse who was coordinating the shift and triaging ambulance borne patients, to provide patient care.
- During our visits we saw that the senior nurse was frequently diverted from their coordination role to provide patient care. On one occasion we saw the senior nurse serving breakfast to a patient. This resulted in the phone not being answered. On another occasion the senior nurse was providing care to a patient, resulting in a patient handover from the ambulance crew being delayed. Staff in the resuscitation area and in triage were also used flexibly to support the majors area where activity allowed.
- Staffing levels at night were particularly a concern. On the first day of our visit, staff who had just completed the night shift told us they had experienced a busy and "difficult" shift. The shift had been fully staffed, although two of the nurses on duty were temporary staff. Two seriously injured/ill patients had arrived in ED at the same time and assistance was required from outside the department to manage these emergencies and other patients in the department. Support was provided by nurses from the hospital at night team, the clinical site manager and the critical care outreach team. Although their support was welcome one staff member commented that these staff were not familiar with ED and therefore they were not as effective as regular staff members. One nurse described to us the pressure they were under at night with just one nurse caring for 10 patients in majors. They told us that the critical care outreach team was frequently called upon to support staff in the resuscitation area in order "to stop majors grinding to a halt". They told us "I have sometimes gone home and cried."
- Despite the fact that an additional 'floating' nurse shift had been established in the middle of the day, specifically to cover breaks, many nurses told us they were regularly unable to take their breaks. Some staff had reported this via the incident reporting system but most staff told us that after a busy shift with no break they did not have the energy to do this. There was a feeling of resignation and a belief that nothing could be done to resolve this concern.
- On the day of our unannounced visit the floating nurse shift had not been filled and the nurse in charge told us it was difficult to allocate staff all staff their breaks. In the early afternoon we asked the triage nurse if they had been able to take a break. They told us they had taken a short tea break at 10.30am. They were working a 12 hour shift (8.30am to 8.30pm). They told us it was unlikely they would get a further break because they and the nurse in charge were the only two staff on duty who were trained to perform triage. We were concerned that

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this staff member was required to undertake this intensive role for a prolonged period without sufficient breaks. There was a risk that they would become fatigued and less effective in their role.

- The staffing situation described above was compounded by the fact that The ED had a significant number of nurse staff vacancies (1.11 WTE band 6, 3.3 WTE band 5 and 3.3 WTE band 2). There were also a significant number (6.6 WTE) of staff on long term absence. The trust monitored actual staffing levels against planned levels shift by shift. Data showed that the ED was consistently filling shifts. However, the department relied heavily on bank and agency staff who were regularly deployed in addition to existing staff who worked extra shifts to cover shortfalls in the rota. We looked at the nurse staff rosters between 16 November and December 2015. The percentage of temporary staff deployed each day ranged from 26% to 66%, with the average being around about 40%.
- Nursing staff told us that some temporary staff did not have adequate skills or experience to perform competently and safely in ED. The deputy lead nurse for ED told us that they had developed a range of essential and desirable competencies for temporary staff so that they could be assured that temporary staff were appropriately experienced and skilled. However, they were unable to provide these competencies and we were advised to contact the bank office to obtain them. When we contacted the bank office, the staff member we spoke with was not familiar with these competencies and told us that as long as a nurse had a PIN number, indicating they were registered with the Nursing and Midwifery Council, they would be permitted to work in ED. During our unannounced visit an agency nurse was deployed in the SSEU in the afternoon, swapping with the substantive nurse who had been on duty in the morning. The nurse in charge explained that the agency nurse did not have the required competencies to be effective in the ED.
- Temporary staff were required to complete a ward orientation form at the beginning of their first shift in the emergency department. Temporary staff working during our visit confirmed that they had completed this orientation. There was a system in place which allowed senior staff to feed back on the performance of temporary staff.
- There was not a dedicated paediatric trained workforce in ED. The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency Care Settings (2012) identifies that there should always be registered children's nurses in ED or trusts should be working towards this. There were 4.69 whole time equivalent (WTE) registered nurses employed in ED, who were dual-trained to care for adults and children. There was an additional one WTE who had completed external training to achieve competencies to care for children. The ED was unable to ensure there was always an appropriately qualified nurse on duty. We were told by the management team that support could be obtained for the children's ward. However, this relied on goodwill and a nurse told us that they did not consistently receive support, which they felt was dependant on who was on duty.
- The department had taken some steps to mitigate this risk.
  - There was a paediatric best practice group led by a senior nurse who was dual-trained. This group was a source of information and advice to the wider adult nurse team.
  - There was a business case to employ an additional registered nurse in the minors department. It was proposed that with structural changes to the department (which had been agreed), this nurse would then be able to support the care of children. Discussions were ongoing with regard to the necessary staff education and training required to support this. This included joint working with the children's ward, rotations and secondments; however a detailed plan and timescale for this development had not been developed.
  - We were told that all nursing staff were trained in paediatric life support (PLS), as recommended by the RCHP. Data provided showed that six staff had not completed this training but were scheduled to receive training later in the month of our inspection. All nursing staff and healthcare assistants were required to acquire and be assessed against a range of paediatric competencies within 12 months of starting work in ED. However, the trust was unable to confirm how many staff had acquired these competencies.



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- **Medical staffing**

- There was consultant presence 15.5 hours a day (8.30am to midnight) and senior medical cover was provided on call outside of these hours. Concerns were recorded on the department's risk register with regard to the lack of senior medical cover in the department at night. Following their visit in February 2015 the Emergency Care Intensive Support Team (ECIST) raised concerns that there was no middle grade or consultant cover overnight. This, they noted, combined with the lack of seniority of nursing staff at night, meant that there were no senior decision makers on duty. They recommended that this be reviewed as a matter of urgency. The trust's action plan which was developed in response to ECIST's recommendations stated that a paper outlining a range of options to address this situation had been submitted to the medicine division's management team.
- The lead ED consultant acknowledged that there were "huge pressures on the consultant body" and that demands on ED consultants were greater than the norm. Consultants reported that they sometimes worked beyond midnight, until 1am or 2am to provide support to junior doctors. They told us they were concerned that this situation could not be sustained long term, in the context of increasing demand on the service and the age profile of the consultant body.
- The lead consultant described the steps the department had taken to mitigate the identified risk:
  - Consultants on call were able to respond quickly to calls for support. They told us that consultants who lived more than 150 minutes away were resident when on call. The on call room was located within five10 minutes' walk of the ED.
  - Consultants attended for all trauma patients.
  - There was support available from doctors and senior nurses in the wider hospital. There was a hospital at night team led by a medical registrar and supported by a clinical site coordinator, anaesthetists, junior doctors in medicine and surgery and paediatrics, and a critical care outreach team. The hospital at night handbook described the responsibilities of this team to support junior doctors in ED overnight and referral pathways were outlined.
  - Consultants reviewed the records of all patients discharged from ED overnight. This provided an

effective safety net. We saw an example of a patient who was discharged from ED at night after appropriate tests. Although the management of the patient had been appropriate, the consultant called the patient back for further tests the following morning after reviewing their records.

- Junior medical staff were generally happy with the level of consultant and senior medical staff cover at night because there was support from elsewhere in the hospital. It was acknowledged by both junior and senior medical staff that the effectiveness of this arrangement relied on goodwill. There was also concern expressed by one junior doctor that support from elsewhere in the hospital may sometimes be provided by a similarly junior doctor.
- Locum medical staff were rarely employed and were usually bank staff, rather than externally employed doctors.
- There was an induction package for locum staff and all locums were reviewed by a substantive consultant to ensure their competence.
- There were two consultants with a special interest in the care of children. Medical staff had received appropriate levels of life support training for children.
- **Other Staffing**
  - A portering service was provided by a trust-wide team. Staff reported that response times were variable and they were encouraged to report any significant delays. During our visits we observed nurses frequently undertook portering duties such as taking patients to x-ray.
- **Major incident awareness and training**
  - There was a draft trust-wide major incident policy in place which had been widely communicated across the organisation. There was an emergency department business continuity plan and impact assessment available in the emergency department and held on the trust's emergency planning shared drive. and a lack of written guidance for staff in relation to disaster contingency planning. This was identified on the ED risk register but had been highlighted as a risk since 2001 and it was unclear from this document how this risk was being managed. A senior nurse told us that theoretical training to raise staff awareness in major incident

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management was provided at annual mandatory training updates but practical training had not been provided for a number of years. The trust told us that a trust-wide multi-agency major incident exercise was held in April 2015. In addition, three staff had been trained as trainers, including a consultant, charge nurse and senior nurse. There was a supply of laminated action cards attached to lanyards, which were kept in the majors department and which outlined responsibilities for each staff role in the event of a major incident. There was also a resource board which would provide a central point of information to assist oversight and coordination of an incident.

- There was an Emergency Department Chemical Incident Plan March 2013, which was currently under review. An ED consultant and a senior nurse had recently attended a 'train the trainer' course on arrangements to deal with a chemical, nuclear, radiological and nuclear (CBRN) incident. A cohort of eleven staff had also recently attended theoretical CBRN training.
- There was a permanent, fully equipped decontamination unit adjacent to the ED.
- There were security staff employed in the hospital who could be called upon to support staff in the ED. We were told that they were responsive to calls for assistance. Staff were trained in control and restraint.
- In CQC's 2014 A&E survey the trust scored 9.7 out of 10 in response to the question which asked patients if they felt safe in the ED.

## Are urgent and emergency services effective?

(for example, treatment is effective)

Good



Patient's care and treatment was planned and delivered in line with current evidence-based guidance and standards. There was a comprehensive emergency department handbook which contained clinical guidance and protocols. We saw good levels of compliance with recognised care pathways, including those for sepsis and stroke care.

Compliance with protocols and standards was monitored through participation in national audits. Performance in national audits was generally about average compared with other English trusts, with the exception of the Royal College of Emergency Medicine (RCEM) mental health audit where performance required improvement. There were action plans in place to make improvements where shortfalls were identified. A range of local audits had also been undertaken. We saw little evidence of local audit.

The trust's un-planned re-attendance rate was consistently lower (better than) the England average. This is an indicator that care and communication with patients was effective.

Junior doctors felt well supported with regular education and supervision. Consultants reviewed the records of all patients discharged overnight and junior doctors were able to invite patients back for consultant review.

Nursing staff did not benefit from the same level of structured education and supervision. The trust was unable to provide us with information which assured us that nurses were able to access regular education or informal and formal supervision.

The service worked well with other teams and services so that people received seamless care. Care was delivered in a coordinated way, with support from specialist teams and services. There were excellent working arrangements with the Acute Medical Unit, which worked closely with the ED as part of the 'front door team'. There were clear policies agreed with specialty doctors which formalised their supportive role to ED and reciprocal support was offered by ED consultants to junior doctors in other specialties.

## Evidence-based care and treatment

- Care and treatment was delivered using recognised clinical guidelines, for example, National Institute for Health and Care Excellence (NICE) guidelines and the Royal College of Emergency Medicine's Clinical Standards for Emergency Departments. There was a comprehensive ED handbook which contained clinical guidance and protocols, internal procedures and processes.
- We saw evidence that guidance and protocols were followed. We reviewed a sample of records for patients who had presented to the ED with chest pain. Records were well documented and showed appropriate

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management and senior review. The ED had developed a set of non-standard risk factors to stratify cardiac risk for a fast troponin test. (this is a **test**. This had reduced length of stay in the department significantly.

- There was good awareness of and engagement with the sepsis protocol. This was demonstrated by speaking with staff and by reviewing a sample of records.
- There were clear pathways for patients who presented with stroke symptoms and we saw good joint working with the stroke team.
- There was an effective 'see and treat' service provided by emergency nurse practitioners (ENPs). Five of the seven ENPs were trained as non-medical prescribers. This meant that they could supply and administer a range of medicines without referral to medical staff.

## Pain relief

- Patients we spoke with told us they had received adequate and prompt pain relief. Records we examined demonstrated that pain was mostly assessed promptly and reassessed at appropriate intervals and pain relief was offered as appropriate. However at busy times when there were delays in the triage process there was a risk that pain relief was not offered promptly.
- We reviewed the record of a patient who arrived in the ED at 2am on 3 December 2015. A pain score of eight out of ten (high) was recorded but no pain relief was administered during the six hours they were in the department.
- In the CQC 2014 A&E survey the trust scored eight out of 10 in response to the question which asked patients if staff did everything they could to control their pain, although the score was only 6.9 out of 10 in response to the question in relation to waiting too long to receive pain relief if requested.

## Nutrition and hydration

- There were no set drinks rounds undertaken in ED, although we observed staff providing drinks from time to time. Patients we spoke with confirmed that had been offered and/or provided with food and drink. Nursing documentation in ED and SSEU did not consistently record when patients were offered food and drink so we could not be assured that this occurred regularly.

- In the CQC 2014 A&E survey the trust scored 7.13 out of 10 in response to the question which asked patients whether they were able to get suitable food or drinks when they were in the A&E department. This was about the same as other English trusts.

## Patient outcomes

- Information about patient outcomes was routinely collected and monitored. The trust participated in national Royal College of Emergency Medicine (RCEM) audits so they could benchmark their practice and performance against best practice against other EDs. Action plans had been developed to improve performance where shortfalls were identified.
- In the RCEM 2013-14 audit of severe sepsis and septic shock there was variable performance. The trust scored in the average quartile for seven indicators, in the upper quartile for three indicators and in the lower quartile for two indicators. The trust was required to meet a standard set and monitored by its commissioners (commissioning for quality and innovation standard - CQUIN) in relation to the treatment of sepsis. This required that patients were screened for sepsis and that for those patients where sepsis was suspected, that intravenous antibiotics were administered within one hour of arrival in ED. In October 2015 the ED reported that 100% of appropriate patients had been screened and antibiotic treatment had been initiated within the hour for 80% of cases.
- We observed that a sepsis screening tool was consistently used for all patients who had an early warning score of three or more.
- In the 2014/15 RCEM audit of initial management of the fitting child the trust performed in middle quartile for all indicators, compared with other English trusts.
- In the 2013/14 asthma in children audit the trust's performance was mostly in the middle quartile nationally.
- In the 2014/15 mental health in the ED audit the trust performed poorly and was in the in the lower quartile for five of the nine indicators, two of which were classified by the RCEM as fundamental standards which all providers should meet. These standards related to the completion of a risk assessment and the provision of a dedicated assessment room for mental health



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patients. We saw that the emergency department had a dedicated assessment room for mental health patients who require an assessment by a mental health practitioner. The audit showed that 93% of patients were assessed by a mental health practitioner in a dedicated assessment room.

- In the 2013/14 paracetamol overdose audit the trust performed in middle quartile compared with other English trusts.
- In the 2014/15 audit: assessing for cognitive impairment in older people the trust's scores were in the upper quartile for three indicators, in the middle quartile for two indicators and in the lower quartile for one indicator. The trust failed to meet the fundamental standard which requires that an early warning score is documented, although it scored above the national average. .
- The unplanned ED re-attendance rate within 7 days was consistently better than the national standard of 5%. Year-to-date performance reported in August 2015 was 2.5%.
- There was an effective system to reconcile all radiology diagnosed fractures with patients' notes. A review took place every day by a consultant. There was a consultant-led ED review clinic where junior doctors could refer patients who had attended overnight when they needed a senior review. Consultants also reviewed the records of all patients who had absconded from the department and children who had not presented for a review.

## Competent staff

- We could not be assured that nursing staff had the right qualifications, skills, knowledge and experience to do their job. There was no identified education lead for nursing staff and no department-wide overview or oversight of nurse staff competencies. We did not therefore have assurance that all staff had appropriate and up-to-date competencies.
- The deputy lead nurse had responsibility for coordinating and rostering training. They told us that the department held dedicated team (training) days, which included mandatory updates, competency assessments, safeguarding supervision, as well as but mainly focused on those areas identified by

staff, where they would like further education. The team days were attended by the ED lead and deputy lead who provided updates on quality and operational issues such as complaints and performance.

- The trust told us that they had developed a range of competencies for band 5 and band 2 staff and these were to be released shortly, followed by band 6 staff. This would enable staff to develop and progress within their roles.
- There was a system in place to provide informal and formal supervision of nursing staff. The trust told us that senior nursing staff had been trained to undertake staff supervision. The deputy lead nurse in ED told us that all nursing staff were assigned to a mentor group led by a senior (band 6) nurse. There were five mentor groups and an ENP was linked to each group. The senior nurses were allocated one day per month to undertake their supervisory role. We were told that this included one to one supervision of the staff in their mentor group. The deputy lead nurse was unable to provide any evidence that this was taking place consistently or regularly. They told us that one senior nurse had been absent for six months and another had been absent since September 2015 so there was "some catching up to do". Staff were rostered to work night shifts with their mentor so that they had opportunities to work together, allowing a form of informal supervision. We were told that each staff member should attend one mentor training day and one mandatory training day per year and but limited evidence was provided to support this.
- The deputy lead nurse did not know how many staff had received their annual performance appraisal, although they told us that they thought they were "doing ok". Data subsequently provided by the trust showed that only 72% of nursing staff and 38% of Emergency Nurse Practitioners had had received a performance appraisal in the last 14 months.
- Nursing staff were encouraged to research and develop areas of interest and act a source of advice and training for the team. There were link nurses identified in areas such as dementia care, alcohol misuse, and bereavement. However, due to staffing pressures in the department, dissemination of information and learning took place in an ad-hoc and unstructured way.

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- There was protected time for medical staff teaching. Junior medical staff felt well supported. A consultant told us that two of the recent cohort of trainee doctors had decided to pursue a career in emergency medicine following their placement in Salisbury ED. Medical staff had received regular performance appraisal.

## Multidisciplinary working

- Care was delivered in a coordinated way with support from specialist teams and services. There were excellent working arrangements with the Acute Medical Unit, which worked closely with the ED as part of the “front door team”. There were clear policies agreed with specialty doctors which formalised their supportive role to ED and reciprocal support was offered by ED consultants to junior doctors in other specialities. For example, an orthopaedic specialist registrar would attend ED with an anaesthetist to perform a joint reduction (dislocation) if this had not been possible using gas and air.
- We saw examples of excellent multidisciplinary working.
  - Radiology services were reported by ED staff to be accessible and responsive, with a good range of services available until 8pm and a more limited range available out of ours. Staff told us that radiology reporting was very prompt, with the majority of CT scans being reported on within one hour. Radiology systems were linked with centres in Southampton, Bournemouth, Portsmouth and Basingstoke so that images could be viewed in these tertiary centres in real time.
  - ED staff reported that the pathology service was reliable and responsive.

## Seven-day services

- There was senior medical staff presence in the ED seven days a week. Other services, including radiology, mental health liaison and therapy services were also available.

## Access to information

- There was a paper-based patient record which was pre-populated electronically with patients’ demographic details. Care and treatment was recorded manually and completed records were scanned by reception staff on to the electronic system.

- There was an electronic information system which allowed staff to view activity in the department as a whole. This was an effective tool to help staff manage patient flow, although there were problems reported by staff who were not able to see attachments (identified by a paperclip icon) which may contain important patient information. This information had to be requested from, and printed by, reception staff.

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

- Staff demonstrated a knowledge and understanding of their responsibilities in relation to the Mental Capacity Act 2005 and consent.
- There was little reference to patients’ consent recorded in their records. However, we observed doctors and nurses asking patients’ permission before they undertook examinations or provided care or treatment. They also explained the reasons for undertaking tests.
- There was an information sheet and consent form used to explain procedure and record written consent for the disposal of early pregnancy tissue. This sensitively explained options.

## Are urgent and emergency services caring?

Good



We observed that all staff treated people with compassion, kindness, dignity and respect. Staff introduced themselves and spoke with people in a friendly and polite manner. They responded in a caring and compassionate way when people experienced pain, discomfort or distress.

Patients and their relatives were involved as partners in their care. Staff took the time to explain to patients and their relatives about their care and treatment. This was done sensitively and in a way that people could understand.

The department had established an outstanding service to support bereaved relatives.

Feedback we received from patients and visitors was consistently positive. We spoke with many patients and visitors. Unusually, we were approached by some patients

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who were very keen to tell us how well they had been looked after. This feedback was consistent with results from patient satisfaction surveys. Friends and family scores were consistently high, with over 90% of respondents indicating that they would recommend the service.

The ED scored better than other trusts in the CQC 2014 A&E survey, with a score of 8.4 out of 10 in response to the question which asked patients if they would rate their experience overall as 'good'.

## Compassionate care

- The trust used the friends and family test to capture patient feedback. Results for the ED were consistently good, with the majority of respondents indicating they would recommend the service to friends and family. One patient, who was one of many who provided positive feedback about their experience in ED during the week prior to our visit, commented: "Greeted by x in a very friendly and professional manner, treated by consultant y who immediately put me at my ease and dealt with me superbly. Well looked after by z. Well done and thanks to all."
- We also received almost universally positive feedback from patients and visitors during our visits. Patients told us that all staff, including receptionists, nurses and doctors, were polite and friendly. One patient described the care they had received as "brilliant". They said they had received constant reassurance and had been treated as if they were the only patient in the department.
- We observed an example of outstanding compassionate care provided to a distressed patient in the resuscitation area. They showed great empathy through their verbal and non-verbal responses.
- Patients' privacy and dignity were mostly respected. In CQC's 2014 A&E survey, the trust scored 9.2 out of 10 in response to the question which asked patients whether they thought that overall, they were treated with dignity and respect while they were in the ED. We saw staff taking care to maintain people's privacy and dignity, drawing curtains where appropriate. We observed a triage nurse check with a patient that they were happy for their colleague, who had attended with them, to be

present during their assessment. However, on the short stay emergency unit we saw on a several occasions patients were not appropriately covered to protect their dignity.

- Patients received respectful and considerate care. In CQC's A&E survey the trust scored 9.1 out of 10 in response to the question which asked patients if staff did not talk in front of them as if they weren't there. A patient told us they had appreciated the time that staff had taken to explain their condition clearly and, even though the department was very busy, they didn't feel their care had been rushed.
- We observed that staff were friendly and courteous. They introduced themselves by name and role and spoke with people politely and respectfully.

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

- Patients and those close to them were involved as partners in their care. In CQC's 2014 A&E survey:
  - 8.3 out of 10 in response to the question which asked patients whether they were as involved as much as they wanted to be in decisions about their care and treatment.
  - The trust scored 8.6 out of 10 in response to the question which asked patients whether they felt the doctor or nurse explained their condition and treatment in a way they could understand.
  - The trust scored 9 out of 10 patients in response to the question which asked patients if they felt the doctor or nurse listened to what they had to say.
  - The trust scored 8.2 out of 10 in response to the question which asked patients whether their family or someone else had enough opportunity to talk to a doctor if they wanted to.
- Patients and relatives told us they were kept informed about what was happening and what would happen next.
- We observed a doctor speaking over the telephone with a relative of a patient who had just arrived in ED. They explained clearly and sensitively what was happening to the patient and what tests they were going to carry out. They then took the phone to the patient so that they could speak directly with their relative.

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- We observed that all young children who attended ED were given a teddy bear. We saw also that children were given a copy of their x-ray to take home. Parents told us they were impressed that staff spoke to their children, rather than just addressing the parents and that everything was explained to them in a way that they could understand.
- **Emotional support**
- In CQC's 2014 A&E survey the trust scored 6.7 out of 10 in response to the question which asked patients if they felt reassured by staff if they were distressed while in A&E. The trust scored 7.8 out of 10 in response to the question which asked if they had any anxieties and fears about their condition or treatment, a doctor or nurse discussed these with them.
- There was a bereavement service in the ED/SSEU. Details of the service were sent with sympathy cards to bereaved relatives. A dedicated nurse worked in the ED three hours one day a week providing support to bereaved relatives in person or by telephone.
- There was understanding and sensitive care provided to patients who had miscarried in early pregnancy. Patients were transferred to the Benson Suite, a bereavement suite in the maternity department dedicated to caring for families who had lost their baby.
- We saw feedback received from a patient who had recently attended the ED with suspected Ebola. They wrote: "I have received outstanding care, attention and thoughtfulness over the past 60 hours...I was so impressed by the way the nurses were called off wards and the chaplain sat with me outside the isolation unit for hours on end. In the short stay I saw again the vast array of what your staff deal with. Thank you so much."

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

Requires improvement



Services were not always responsive or organised and delivered so that all patients received the right treatment at the right time to people's needs.

Premises and facilities were largely appropriate for the services delivered; however children were cared for in the adults' department which was not an appropriate environment for them because they were exposed to sights and noise which may cause them stress. The children's waiting room, whilst bright and welcoming, was overlooked by and could be accessed by adult patients and visitors. Patients' privacy and dignity was sometimes compromised on the short stay emergency unit. The ward was cramped and the layout did not always allow for single sex accommodation to be provided.

The needs of patients in vulnerable circumstances were not always met. Patients with mental health needs, particularly children and adolescents, who required assessment by a mental health practitioner, did not always receive a responsive service. This meant that these patients experienced long waits which could be detrimental to their mental health and they were sometimes admitted to hospital unnecessarily.

The department had not taken adequate steps to support patients living with dementia or those with a learning disability.

The ED was consistently meeting national standards in respect of the time people spent in the department, and the time they waited for treatment, although this was becoming more challenging with increasing demand on the service. There were relatively few ambulance handover delays but at busy times, some patients queued on ambulance trolleys in the department and this impacted on their comfort, privacy and dignity.

The ED worked well with the patient flow team and the rest of the hospital to minimise blockages and overcrowding in ED. The trust had invited an external review of patient flow by the emergency intensive support team (ECIST) and had developed an improvement plan based on their recommendations and had taken some immediate actions, although some changes required time to embed. Further improvements were planned but required time and resource.

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

- The emergency department (ED) was well sign posted, both within the hospital building and within the hospital grounds. There was a drop off zone and parking was available close to the department. A staff member

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arrived twenty minutes late for their shift during the day of our visit because they had experienced difficulty finding a parking space. Staff reported that this was a regular problem for staff and visitors.

- Steps had been taken to ensure patients' privacy and dignity. There were side rooms in majors, which allowed private discussions or examinations to take place. At the reception desk, the floor had been painted to create a standing area, designed to prevent queuing patients overhearing others' private conversations. In CQC's 2014 A&E survey the trust scored 7.6 out of 10 in response to the question which asked patients if they had enough privacy when discussing their health problem with the receptionist.
- The trust scored 9.1 out of 10 in response to the question which asked patients whether they were given enough privacy during examinations and treatment. However, the triage area was not private, with only a curtain to screen one entrance to it. This meant that conversations could be overheard by patients waiting to see the out-of-hours doctor.
- The short stay emergency unit did not consistently provide single sex accommodation.
- Waiting rooms provided adequate seating to accommodate patients and visitors during our visit. However, staff told us that at busy times there was sometimes insufficient seating and patients and visitors had to sit on the floor.
- Patients had access to vending machines where they could purchase hot and cold drinks and a range of healthy snacks.
- There were toilets suitable for adults and children and nappy changing facilities were available. A sign at reception advised that a suitable area could be identified on request for breast feeding mothers.
- There was a dedicated children's department within the ED; however, due to a shortage of nursing staff with paediatric competencies, the department was not being utilised because it could not be adequately staffed. This meant that children were assessed and treated in the adults' department, although there was one designated children's cubicle which had been decorated and equipped for children.

- Patients were given information so that they knew what to expect during their visit to ED. Waiting times were displayed in the ED waiting room. In CQC's 2014 A&E survey the trust scored about the same as other trusts in questions relating to waiting times, although they scored particularly poorly in relation to not being told how long they would have to wait before being examined by a doctor. Patients who self-presented at the ED reception were given written information about pathway they were likely to follow while in the department. This helped them to understand the flow of the department, what to expect and how long they may spend in the department.

## Meeting people's individual needs

- Services were not planned or delivered to take account of people with complex needs, for example those living with dementia or those with a learning disability. We asked the trust to tell us how they supported this group of patients. They told us that staff had not received specialist training to support people living with dementia or people with a learning disability but they had designated link nurses who acted as a source of advice and support to staff. We spoke with the designated dementia care link nurse. They were unable to describe any particular steps taken to support this group of patients, other than trying to locate them in cubicles where they could be easily observed by staff. Patients living with dementia were not identified on the electronic patient record system on the department's whiteboard or at their bedside. This meant that visiting staff, such as housekeepers may not be alert to their particular needs.
- There was a designated ED consultant lead for care of the elderly, who had a special interest in dementia care. The electronic patient record had been updated approximately six months ago to include an abbreviated mental test (AMT) score for patients over 75 years of age. The consultant lead told us they were trying to embed this into the culture in ED. There were plans to have the AMT score included in the electronically generated discharge letter to GPs to facilitate appropriate follow up of identified patients. There was joint working ongoing with the care of the elderly physicians in the hospital to develop a dedicated pathway for the direct admission of



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frail, elderly patients to a care of the elderly ward. There were also plans to adapt some ED cubicles to make them “dementia friendly”, although no funds had been identified for this yet.

- We observed and spoke with a patient who was living with dementia, who was in a side room on the SSEU. They were anxious, agitated and confused but staff did not have the time to spend time with them to offer reassurance. They were not easily observed in the side room and they had not been given a call bell. We spoke with a consultant later in the day because we were concerned that patients living with dementia may not receive the attention they needed on this ward. The consultant explained that the patient had been admitted to SSEU because there were no suitable speciality beds available in the hospital. They acknowledged that a side room on this unit was not the most appropriate environment but felt that this was preferable to spending the night in a busy ED. They told us that dementia was not an exclusion criterion for admission to this ward.
- In the 2014/15 Royal College of Emergency Medicine (RCEM) audit: assessing for cognitive impairment, the trust scored in the lower quartile compared with other English trusts for the documentation of an early warning score. The trust scored only 21% against a standard of 100%. We looked at a sample of records for older people and found that the AMT score was not consistently completed.
- The ED was accessible for people with limited mobility and people who used a wheelchair. Wheelchairs were available at the department’s entrance.
- Reception staff told us that a telephone interpreter service was available for patients/visitors whose first language was not English. They told us they also called on staff in the hospital to assist with translation. Hearing loops were not provided in reception to assist people who were hard of hearing.
- There were arrangements in place for patients who presented to ED with mental health issues, including those who had self-harmed. There was a mental health liaison service based in the hospital ED, which was provided by the local mental health trust and which

operated from 9am to 5pm, seven days a week. The trust could not provide data to demonstrate how responsive this service was but they captured feedback from staff, who commented as follows:

- In hours the liaison team provided a responsive service to adults and responded to emergency referrals within 60 minutes as recommended by the Royal College of Psychiatrists (RCP). The standing operating procedure for the mental health liaison team stated that the benchmark standard for urgent referrals was five hours - same day. It was not clear whether this was achieved.
- Prolonged delays were experienced when a mental health assessment requiring a section 12 approved doctor and an **approved mental health professional** was required.
- Out of hours, only severe emergencies were seen and only if there was no concurrent medical problem. The target for seeing emergency patients was four hours. This did not meet the RCP standard and the consultant lead for mental health told us it was not fast enough. It was reported that most patients waited more than 12 hours for a mental health assessment or were discharged without an assessment. The consultant lead told us that many patients, who were assessed as a moderate risk, were admitted unnecessarily overnight because they were waiting for an assessment by a mental health practitioner. This put pressure on bed availability and was not responsive to the needs of these patients. The trust had signed up to the mental health crisis care concordat and was actively working with the local mental health trust and other organisations to improve services. The trust met with the local mental health trust to discuss concerns.
- There was a Child and Adolescent Mental Health Service (CAMHS) available during daytime hours. It was reported that most patients waited 24 hours or more for an assessment and there was no emergency support available. The consultant mental health lead told us that the service was limited by the commissioning arrangements in place and that they had written to the commissioners to raise their concerns about the level of service currently commissioned.

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- The 2014/15 RCEM audit of mental health in ED highlighted that there was no dedicated assessment room for mental health patients, as recommended by the psychiatric liaison accreditation network (PLAN) and endorsed by the RCEM. There was in fact a dedicated assessment room in the ED. This had two doors as recommended by PLAN; however, furniture and fittings did not comply with guidance because items could potentially be used to cause harm to the patient or other service users.
- There was a hospital-wide alcohol liaison service. An alcohol liaison nurse visited the short stay emergency unit each weekday morning to offer support where required. They could also be contacted by bleep at other times of the day and ED staff could arrange a follow up consultation following a patient's discharge. The service was not provided at weekends or at night. A number of staff in the ED had received specialist training to become alcohol advisors to support people who presented with problems relating to alcohol misuse. A healthcare assistant who had received this training showed great enthusiasm and had developed a resource folder for staff with guidance to help them support this patient group.
- In the Royal College of Emergency Medicine (RCEM) audit: assessing for cognitive impairment, the trust scored in the lower quartile compared with other English trusts for the documentation of an early warning score. The trust scored only 21% against a standard of 100%. The patient record generated for patients over 65 years of age required that an abbreviated mental test was carried out. Patients were asked four questions to generate a score out of four. Any patient who scored less than four was then required to have a further mental assessment. We found that this test was not consistently recorded in patients' notes. We could not be assured that a proper assessment of their cognitive ability was undertaken, which may have impacted on care and treatment they subsequently received.
- 4 hour performance - this standard requires that 95% of patients are discharged, admitted or transferred within four hours of arrival at A&E. The department was consistently achieving this target and reported a year-to-date performance of 96.4% in August 2015.
- Left without being seen – this measures the percentage of patients who leave the ED before they have been seen by a clinician and is indicative of patient dissatisfaction with waiting times. The national standard is that this should be below 5%. The trust reported a year-to- date performance of 1.2% as at August 2015.
- Time to treatment - this measures how long patients wait for their treatment to begin. A short wait will reduce patient risk and discomfort. The national target is a median wait of below 60 minutes. In August 2015 the trust's year-to-date performance was 48 minutes.
- Ambulance handovers – this measures the number of ambulance handover delays of over 230 minutes. The trust reported there had been 28 such delays in the year to date (April to September 2015, of which six were over 60 minutes. Following their visit in February 2015 ECIST reported that the process for taking ambulance handovers was outstanding and reduced delays in assessment and requests for further investigations. Ambulance staff we spoke with told us that handover delays were infrequent and they felt that the ED staff dealt with this process efficiently.
- Time to admit – this measures the time that patients, who require admission to a hospital ward wait from the time of decision to admit. (percentage of patients waiting four to twelve hours). The trust mostly performed better than the England average, although a dip in performance was seen in October 2014 and January 2015.
- Trolley waits - this measures the number of patients who wait more than twelve hours on a trolley in ED. There were no such delays reported in the year-to-date date as at August 2015.
- The department consistently achieved the national target which requires the number of patients who leave the department before being seen (by a clinical

## Access and flow

- The ED was consistently meeting most of the national quality indicators:

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decision-maker) should be less than 5% (recognised by the Department of Health as being an indicator that patients are dissatisfied with the length of time they have to wait).

- Patients sometimes queued in the corridor because there were no cubicles available. This was the case during our unannounced visit at the weekend. This impacted on patients' comfort, privacy and dignity.
- Patients sometimes stayed in the ED overnight because there were no beds available in the hospital. They were provided with hospital beds if this occurred.
- Although the four hour standard was being met, it was becoming more challenging. Following their visit in February 2015 the Emergency Care Intensive Support Team (ECIST) made a number of recommendations to improve patient flow. Their recommendations resulted in the production of a patient flow action plan that was managed by a project management board, overseen by the Chief Operating Officer. These included: recommendations were:
  - The introduction of a rapid assessment and triage (RAT) at times of peak demand. The trust's action plan (November 2015) confirmed that RAT was used occasionally. A RAT protocol had been produced and had been submitted, along with a bid for the necessary resources to implement this to the divisional management team.
  - A review of the management of tertiary referrals. Patients were referred from other centres for plastics and trauma and orthopaedics and were currently presenting in the minors department for review by specialties. This led to decreased capacity for ED minors and led to delays. At the time of our visit plastic surgeons were holding clinics in the children's ED.
  - Consideration of extending and improving the interface with the GP out-of-hours service. It was noted by ECIST that the GP out-of-hours service was working well in the department but this was variable depending on the demand for GP home visits. It was noted that when the GP was not present in the department the demand defaulted to the ED at its most challenging time in terms of the seniority of staff available. ECIST recommended the development of a primary care team, allowing ED medical staff to focus on the treatment of major illness and injury.
- Undertake a review of appropriate triggers and expected outcomes/actions to be agreed across the organisation with standardisation of the clinical management of the department. The ED had developed internal performance standards aimed at ensuring efficient and timely flow of patients through the ED. These included:
  - Standards with regard to the prompt review of patients in ED by specialty doctors. These required that referrals to specialty doctors were made within two hours and that specialty teams reviewed patients within 30 minutes of the referral. Response times were not routinely monitored but delays were highlighted when four hour breaches occurred as result of delayed response times.
- As soon as a hospital admission was indicated, or at two and a half hours from the time that the patient arrived in ED, the majors coordinator or specialty team were required to request a bed from the bed management team.
- Patients referred by their GP to a named specialty were to be seen directly by the specialty team if the ED consultant deemed this to be clinically appropriate.
- When the wait to see a doctor in the ED was greater than 60 minutes or there was a capacity/flow problem in the ED, the escalation policy was required to be implemented.
- The escalation policy outlined a series of actions to be taken according to the escalation status of the ED. Status was designated 'green', 'orange' or 'red'. Designation of orange or red would be triggered by a range of factors, including staffing levels, number of patients in the department or expected, waiting times and actual or anticipated breaches.
- There was an Expedited Transfer Policy which was enacted when unacceptable delays occurred. This allowed for the expedited transfer of adult patients who had been assessed as clinically stable, to a



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ward. A checklist was completed to ensure that all necessary actions had been taken prior to the transfer taking place. This included a full set of clinical observations and the administration of appropriate pain relief.

- The department operated a 'see and treatment' service in minors. Emergency Nurse Practitioners (ENPs) were employed between 8am and midnight. ENPs are specially trained nurses who are able to see, treat and discharge patients with minor illness or injuries. Staffing levels did not allow for this service to be offered consistently but the department reported that when the middle shift was on duty between 10am and 8pm, patient flow was improved, breaches of the four hour target were fewer and time to treatment times were reduced. There were plans to extend this service.
- There was a "front door" therapy team which provided assessment, treatment and supported discharge of patients. The service was available from 8.30 am to 4.30 pm, seven days a week. Therapists visited the short stay emergency unit each morning to facilitate the discharge of identified patients.
- There were eight beds in the short stay emergency unit (SSEU) which could be used for patients who required a short stay for monitoring. ECIST noted, following their visit in February 2015, that the beds were incorporated into the hospital's overall bed base. This meant the beds were occupied by patients who were awaiting specialty beds elsewhere in the hospital. Blockage of these beds meant that the ED could not always use the unit effectively to help to manage patient flow. During our visit the SSEU was frequently occupied by more specialty patients than ED patients. The internal performance standards developed by the ED stated that specialty patients would not be admitted to the SSEU unless exceptional circumstances existed and permission was granted by the trust senior management and executive team.
- Non-emergency transport was reported by staff to be a barrier to effective patient flow. The agreement with the ambulance provider allowed a four hour window to respond to a request for transport. This meant that patients who were ready to be discharged sometimes experienced lengthy waits and unnecessarily occupied space in ED and SSEU. Staff also told us that the ambulance service did not always arrive within the four

hour window. A nurse who had worked in the short stay unit told us they had recently booked ambulance transport for an elderly patient at midday and the transport did not arrive until after midnight. Staff and managers told us they had repeatedly raised concerns about the level of service provided. This did not appear on the ED/SSEU risk register.

## Learning from complaints and concerns

- The ED promoted 'local resolution of patients' concerns. Posters displayed in the department encouraged patients and relatives to contact the lead nurse if they had any concerns about their experience in ED. The department told us they had received positive feedback from the public about this process and the number of formal complaints received had reduced.
- Complaints leaflets were available in the ED and in the SSEU for those people who wanted to make a formal complaint.
- The ED received few complaints and records showed that complaints were investigated and response to promptly, with areas for improvement identified where applicable.
- Staff told us they were informed about complaints at handover meetings and via email.
- We were told that following a number of complaints about staff attitude amongst reception staff, this staff group had undergone customer service training.

## Are urgent and emergency services well-led?

Requires improvement



The service had not developed a clear vision or a set of values .cohesive strategy. There was a strategy which set out a five year plan in respect of staffing. the service had responded appropriately to recommendations made by an external reviewing body and there were ongoing staffing reviews, which included comparison with other hospitals; however these plans did not form part of an overarching strategy. Staff had not been involved or engaged in developing a vision or strategy and there was limited evidence of patient involvement.

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Risks to service delivery were understood by the management team but risk management processes were not fully effective. The risk register did not capture the multi-factorial risks to patient safety and quality and we could not be assured that risks were appropriately escalated or mitigated.

Staff enjoyed working in this service and the culture was one of mutual respect and teamwork. Staff felt supported and valued by senior managers who were both visible and accessible. However, morale was overshadowed by issues relating to staffing. Staff had little confidence that these issues would be resolved in the short term and it was likely that these issues may have, or may in the future, impact on recruitment and retention of staff.

## Vision and strategy for this service

- The emergency department had developed a mission statement: “Dedicated to providing excellence and compassion in emergency care.” It was unclear whether or how staff had been involved in developing this but staff at all levels articulated similar values and a passion for delivering safe, high quality and patient-centred care.
- There was no overarching strategy for the department. An improvement plan had been developed following an external review had taken place to examine the effectiveness of systems affecting patient flow. The Emergency Care Intensive Support Team (ECIST) visited in February 2015 and made a series of recommendations. Staff’s knowledge of these recommendations and plans to respond to these was variable. There was a review of staffing completed by the ED lead nurse which set out nurse staffing requirements in the context of increasing demand and ECIST recommendations. An options paper setting out medical staffing requirements was also under consideration by the medical division’s management team.

## Governance, risk management and quality measurement

- There was a monthly meeting of senior nursing and medical staff. A standard agenda included risk management and complaints, staffing, performance and teaching and education.

- A risk register was maintained for ED/SSEU but we saw no evidence that it was discussed and reviewed at this meeting or that risks were escalated for review by the division or the board. None of the risks on the ED risk register were graded at such a level that they would be included in the trust-wide risk register.
- The risk register did not adequately reflect either the range or the severity of the concerns that staff and managers reported to us or the risks that we identified during our visit. For example:
  - Nurse staffing levels and the heavy reliance on temporary staff were cited by almost every staff member we spoke with as being their biggest concern. This was not highlighted as a risk on the risk register dated September 2015.
  - The risk register identified that the children’s ED was not being used due to a lack of nursing staff. This meant that children were cared for in the adults’ department where there was only one child friendly cubicle and they were not audio-visually separate from adults. It did not identify the lack of registered children’s nurses or the steps to mitigate this risk. We identified that there were shortfalls in training in paediatric life support or and children’s’ safeguarding training and a lack of information with regard to other specialist training to care for children. This was not reflected on the risk register.
  - Poor compliance with mandatory training was not identified as risk on the risk register.
  - The serious concerns conveyed to us by a senior clinical in relation to the unresponsive CAMHS assessment service were not identified on the risk register.
  - Concerns about the unresponsive patient transport service were not identified on the risk register.
- Staff reported good working relationships with third party providers and partners, including the ambulance services, and the local mental health trust.

## Leadership of service

- We saw calm and supportive leadership from the senior nurse and senior medical staff in charge of each shift. Senior staff were respected by the workforce; staff told

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us that they were visible, accessible and supportive. Divisional managers and site managers were regular visitors to the department and staff regarded them as supportive. The chief executive also had a high profile.

## Culture within the service

- Staff told us they felt respected and valued by peers and managers alike. Team work was frequently cited as one of the areas where the department performed well. Managers talked about the staff team with pride and took opportunities to praise and to thank them.
- Despite staff shortages and pressure of work, we observed that staff morale appeared to be good, although anecdotally, we heard that the department had lost a significant number of nursing staff over the last 12 months because staff had been offered better working conditions elsewhere. Staff told us that healthcare assistants were unhappy about their grading, given the range of tasks they were expected to perform. Staff turnover rates (excluding rotational medical staff) ranged between 2% and 7% between November 2014 and October 2015. The department had not captured detailed information from staff did not conduct exit interviews to help to inform its recruitment and retention strategy.
- Staff told us that they thought their welfare was important to managers. However, documented actions taken on the incident log (May to 31 August 2015) when staff reported not being able to take breaks did not demonstrate understanding or a sympathetic response or a commitment to resolve concerns. For example, in

May 2015 it was reported that staff were unable to take breaks until eight hours into a 12 and a half hour shift. The action taken was recorded as “department fully staffed”.







## Public and staff engagement

- The service used friends and family test to capture views about the service. We were told that all ED staff received this feedback via email on a weekly basis. This meant that staff felt valued and appreciated and also ensured that areas for improvement could be identified and acted upon quickly.
- No other examples of public engagement or involvement were shared with us.
- Staff reported that communication in the department was good. Important messages were communicated at handover meetings. Regular role specific staff meetings were held and minutes were circulated so that staff were kept informed of news and developments. Notice boards around the department displayed a range of information and key messages.
- Staff felt able to raise concerns and felt they would be listened to if they did so. However, there was a feeling of resignation that nurse staffing issues could not be resolved.

## Innovation, improvement and sustainability

- The ED actively participated in research and had enrolled in three clinical research trials.
- The ED bereavement service introduced in 2010 provided ongoing support and advice to bereaved relatives.

# Medical care (including older people's care)

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

## Information about the service

Salisbury NHS Foundation Trust provides medical care and services to a population of approximately 240,000 in Salisbury and Wiltshire.

There are a total of 214 medical beds spread across eight wards. The trust provides acute and general medicine including the following specialties: care of older people, stroke care, cardiology, respiratory medicine, gastroenterology, haematology, oncology, and endocrinology.

The medical assessment unit has 21 beds in a three ward area, which included three side rooms and four ambulatory care trolleys. This is a short stay area which admits patients from the emergency department or through GP referrals. It was open all year round 24 hours a day.

During our inspection we visited the following wards and departments and met with patients and staff;

- Durrington – a rapid access care of the elderly ward
- Farley – a dedicated stroke unit
- Pembroke ward – providing haematology and oncology with an ambulatory care/day case facility
- Pitton – a medical ward which specialises in respiratory medicine
- Redlynch – a gastroenterology ward
- Tisbury – an acute medical unit specialising in cardiology
- Whiteparish – the acute medical assessment unit
- Winterslow – a care of the elderly ward
- Cardiac catheter laboratories and the endoscopy suite

On this inspection, we visited all medical wards during 2, 3 and 4 December 2015 and made an unannounced visit on Sunday 3 December 2015. We spoke with approximately 40 patients, 15 relatives, and 90 members of staff including doctors, nurses, therapists, administrators and housekeeping staff. We reviewed nearly 50 sets of patient's notes and examined information provided to us by the trust.

# Medical care (including older people's care)

## Summary of findings

We rated medical services as good overall. Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them. Learning from incidents was evident and care and treatment within the hospital kept patients safe. Medical cover, nursing levels and skill mix were appropriate to the needs of the patients on the eight medical wards we visited, which included the acute medical assessment unit, the endoscopy suite and the cardiac catheter laboratories.

However, we did identify a breach in regulation in relation to record keeping, and specifically to the documentation of cannulas, catheters and patients' weight.

Care was effective and was delivered in accordance with evidence-based guidelines and current best practice. Staff managed patients' pain well and feedback from patients reflected this. The trust ensured staff were adequately trained and competent to carry out their role.

Staff provided compassionate care and patients were treated with kindness, dignity and respect. Patients spoke positively about their experience of being cared for at Salisbury hospital. They felt included in their care and were kept informed about their care and treatment throughout their stay.

The provider planned services and coordinated care well for patients living with dementia. The layout and appearance of wards provided a suitable environment for these patients. Patients accessed care and treatment in a timely way.

Services were not always responsive to patients' needs and required improvement. The provider could not always assure adequate patient flow within the hospital. This meant that mixed-sex accommodation breaches frequently occurred and patients were moved during their stay, sometimes late at night. The hospital could not always provide a bed for care and treatment of medical patients on a medical ward. These patients were called medical outliers and were admitted to other

wards, outside of medical services. However, staff and patients were always aware of which doctors were providing specialist medical care and treatment to them and nursing staff were competent to deliver their care.

The medical services were well led. Staff were aware of the hospital's vision and values spoke of the family atmosphere of working in the hospital. The leadership, governance and culture promoted the delivery of high quality care. There was a clear set of values driven by quality and safety and staff were familiar with these. The trust engaged its patients and visitors regularly to obtain feedback in order to improve the patients' experience in the hospital. Staff spoke highly of their managers and felt their views and concerns were listened to and acted upon. The staff survey showed staff recommended the hospital as a place to work.

# Medical care (including older people's care)

## Are medical care services safe?

Good



We found safety in the medical services at Salisbury Foundation Trust to be good overall, although there were some areas requiring improvement.

There was a good culture of incident reporting and learning. The wards were clean and infection control procedures were effective. The design, maintenance, use of facilities and premises kept people safe. Medicines were stored and managed well. Staff identified and responded appropriately to changing risks to patients, including deteriorating health and wellbeing. The hospital joined the national sign up to safety campaign as part of a programme to reduce avoidable harm. Data published as part of this programme showed falls resulting in injury decreased during between 2011 and the end of 2014.

Nursing and medical staffing levels were in line with assessed levels and there was access to temporary staff when required.

Although overall record keeping was good there were aspects that required significant improvement. These related specifically to the documentation of cannulas, catheters and patients' weight. The trust had identified the lack of recording of patients' weight earlier in the year, but practice had not changed.

The trust had improved the decision making around which patients should be isolated in side room facilities. However, at times there was some confusion over which patients required isolation.

Records showed that the target for 85% of staff to have received mandatory training was not met.

### Incidents

- Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them. The National Reporting and Learning System (NRLS) provide comparative data of incidents reported by NHS organisations. The most recent data between October 2014 and April 2015 confirmed Salisbury hospital reported 2,545 incidents, a rate of 33.6 per 1,000 bed days during this period, versus

a national average of 35.4. This shows incident reporting at the trust was comparable to the national average. A high level of incident reporting reflects a more effective safety culture, as it provides the opportunity for learning and improvement.

- The hospital recently implemented a new, electronic incident recording system. The quality and clinical governance report in May 2015 stated this led to higher incident reporting. The hospital reported 12 serious incidents requiring investigation during the period between August 2014 and July 2015. Ten of these incidents were slips, trips or falls. We reviewed a number of investigations carried out following serious incidents. Evidence provided showed how lessons were learnt and actions and recommendations were made following the investigation.
- The hospital had a robust incident reporting procedure. Staff followed the hospital's policy relating to incident reporting, which outlined the process for completing an online incident form. The policy was accessible to all staff through the intranet homepage. Guidance was available on this page, sought from line management, or the risk management department. The induction process provided training in the incident reporting process and was mandatory for all staff at departmental level. The hospital did not provide us with data to show the percentage of staff that had completed this training. Staff felt encouraged and supported to report incidents and received feedback to enable learning from incidents.
- The hospital rated falls as the most common incident. The highest reporting wards were Winterslow, Farley and Redlynch. Senior staff conducted an investigation for all falls resulting in a fracture or major injury. This was a thorough process which enabled learning to be identified and actions to take as a result. For example, a patient under sedation sustained a fall following a coronary angiogram, which is an x-ray procedure used to help diagnose heart conditions. The senior leadership conducted a root cause analysis and created a new post angiography policy, which was shared with staff and implemented as a result.
- Lead clinicians met monthly to review incidents. In one meeting, they discussed two litigation cases. Senior medical staff ensured all relevant departments and staff were updated with appropriate learning points and actions.



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- Senior medical staff told us they held well structured, mortality and morbidity review meetings, which used a standardised audit form. Reviews included investigation of mortality groups for evidence of whether deaths were avoidable. We saw evidence showing that learning points were shared, which enabled improvement. The trust circulated these as emails to all doctors, senior managers and senior nurses.
- The Wiltshire commissioning group found the hospital regularly admitted frail, elderly patients known to be at the end of their life, who died within a day or two of admission. They were working with commissioners and local GPs to enable these patients to avoid admission, if they wished to be cared for at home.
- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a new regulation which was introduced in November 2014. This Regulation requires the trust 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. Evidence received from the trust showed it dealt with such incidents in accordance with the Duty of Candour regulation.
- Staff training records showed the hospital did not include training for the Duty of Candour in its mandatory training. However, training was provided through directorate and departmental meetings and through risk sessions. On two occasions, solicitors provided training during clinical governance half day meetings to advise staff. Staff on the medical wards spoke competently about the hospital policy which outlined the requirements of the Duty of Candour. The electronic incident recording system prompted the reporter about the Duty of Candour when an incident was recorded.
- Senior staff reviewed incidents submitted to the electronic data recording system. This included a review of the grading of the incident, which identified whether it had met the threshold for Duty of Candour. If it did meet this threshold, the ward or department in which it occurred escalated the concern to senior management. The head of risk or the patient safety facilitator reviewed the incident to ensure the investigating manager completed the Duty of Candour documentation.
- When things went wrong, staff conducted thorough reviews and investigations and involved relevant staff in the process. We reviewed a serious incident

investigation report following the death of a patient. It showed the hospital acted in a clear and transparent way when things went wrong. The trust provided the family of the patient a verbal and written apology with supporting information in a timely manner. Staff conducted the investigation in line with the Duty of Candour procedures.

## Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. This data provides a snapshot of avoidable patient harms occurring on one specific day each month. The hospital reported an upward trend to 98% of new harm free care and a slight decline to 94% of all harm free care, in August 2015.
- From July 2014 to July 2015, pressure ulcers occurred at a consistent rate of between one and three per 100 patients each month, falling to a low of 0.4 in November 2014. Falls with harm peaked in August and November 2014, but the rate had otherwise remained below 1.5 per 100 patients each month and showed a downward trend. It showed a rise in urinary tract infections acquired by patients who had catheters, from October through to December 2014. However, rates had otherwise remained below two per 100 patients each month.
- The trust displayed data at the entrance to wards, which contained information relating to key quality indicators found in safety thermometer data. This included the incidence of falls, pressure damage, infection control and venous thromboembolism rates. Pitton ward for example, recorded two falls in May and reported no grade three pressure ulcers since April 2014.

## Cleanliness, infection control and hygiene

- The provider reported in August 2015 that no bacteria methicillin-resistant *Staphylococcus aureus* MRSA or Methicillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemias had occurred during the previous six months. Elective MRSA screening rates had declined and the medicine directorate investigated this with the clinical leads in order to gain improvements.
- In August 2015, the hospital reported two cases of *Clostridium difficile* (a type of bacterial infection that can affect the digestive system). The hospital remained within its trajectory for the number of such cases.



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- Since July 2014, the trust reported it continued to improve decision making around which patients should be isolated in side room facilities, in addition to using the isolation risk assessment tool. It revised the management of patients experiencing diarrhoea and relevant documentation, and created a new patient management pathway. Staff involved investigated the time taken to isolate patients from when they first reported symptoms in order to ascertain the extent of variance against best practice guidance. Findings indicated areas of good practice where staff isolated symptomatic patients within two hours and obtained stool samples. They identified times when patients were not isolated within the target time for a variety of reasons. Infection control nurses monitored adherence to the pathway through daily clinical visits and discussions with clinical staff on duty. The directorate senior nurse observed practices to ensure staff complied with policy.
- During the unannounced inspection, we identified that staff did not always effectively implement systems to prevent and protect patients from a healthcare associated infection. There was some confusion over which patients required isolation. We found some patients in isolation rooms who staff said no longer required it. However, the signs remained in place. Some patients who still needed to be in isolation were in rooms with the doors kept open as the patients were suffering from confusion. Staff had left the doors open as they felt closing the door resulted in the patient becoming more confused. However, infection rates at the hospital remained low.
- Medical wards protected patients through effective antibiotic prescribing. Staff audited the procedures in place to prevent the risk of patients contracting *Clostridium difficile*. The audit protocol selected patient records at random between June and September 2015. These showed compliance with a high percentage of audits. Data provided to us by the hospital related to five of the medical wards only and showed 84.6 % staff had completed mandatory training for infection prevention and control against a target of 85%.
- Staff audited compliance with bare below the elbow, uniform compliance and hand hygiene. Compliance with this is part of the hospital policy and helps reduce the spread of infection. From February to July 2015, bare below the elbow scored an average of 97%. Hand hygiene audits showed that most wards were compliant with hand hygiene, with the average for the directorate, achieving 93.5% between January to August 2015. The poorest performing wards were Whiteparish, Tisbury, Pitton and Redlynch with average scores of 88.9%, 89.7%, 77.4% and 86.9% respectively. Some of these scores did show an improvement over time. Doctors and 'other' healthcare professionals achieved the lowest scores for hand hygiene.
- Ward staff used white boards to identify infection control risks and discussed specific patients as part of the handover and safety briefing. This ensured all staff on the wards were aware of the risks and that effective infection control precautions were taken.
- The hospital had a policy in place for the decontamination of medical devices, patient equipment and endoscopes to provide guidance for the appropriate cleaning and sterilisation of equipment.
- Trained staff cleaned endoscopes in the central sterilising unit, which protected patients from the risk of infection.
- The infection control team updated senior nurses during daily bed management meetings with any infection control concerns and highlighted which beds required a deep clean.
- The wards used green labels to identify when cleaning of the equipment and environment had occurred and who had carried out this process. One commode which had been given a green label was found to have a mark on it. However, it was not clear as to whether this was a stain or dirt and staff took immediate action to investigate this to ensure its cleanliness.
- Chemicals and substances that are hazardous to health (COSHH) were used for cleaning and were stored securely in locked rooms which were inaccessible to patients and visitors.
- Sharps bins were available throughout the medical wards and departments for the safe disposal of used needles and other sharps equipment. Staff used these according to manufacturer's guidance. They kept bins closed when in use and not overfilled, which protected staff from the risk of a needle stick injury.
- Each ward had hand-sanitising gel located at the entrance to the ward. Within the wards, hand sanitising gel and hand washing facilities were available throughout. Posters displayed gave guidance for appropriate usage and correct handwashing techniques. Staff used hand gel and washed hands in line with infection prevention and control guidelines.

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- We saw, and patients confirmed, staff used personal protective equipment such as aprons and gloves when performing procedures and carrying out patient care.
- A number of areas within the medical directorate were part of the national PLACE audit. This is a patient led assessment of the care environment. Durrington, Pitton, Redlynch and Winterslow wards were rated as 98.9% for cleanliness.

## Environment and equipment

- The design, maintenance, use of facilities and premises kept people safe. The PLACE audit rated Durrington, Pitton, Redlynch and Winterslow wards as: 86.2% for privacy, their condition, appearance and maintenance, and 88.4% for a dementia friendly environment. Overall results for 2015 showed an improvement on the previous year and rated better than the England average.
- The provider held guidance and policy documents relating to medical device training, maintenance and management on its website for staff to access. Staff knew how to access a range of policies the trust kept on its website.
- The hospital changed the layout on Redlynch and Pitton wards and refurbished Durrington ward to provide a calm and relaxed environment for its patients.
- The medical directorate reported in August 2015 it had completed its programme of deep cleaning and ward painting within the medical division. This included Durrington ward, Farley stroke unit, Tisbury coronary care unit, Whiteparish acute medical unit and Pitton ward. Wards we inspected were clean, bright and in good decorative order.
- The hospital refurbished Redlynch ward with the aim of providing a light, bright and social environment. Staff used the refurbishment as an opportunity to change practice. These changes included the removal of the nurse's station, which meant staff planned care at the bedside. The hospital recently reported these changes resulted in a 38% increase in reported nursing visibility and a 75% reduction in negative comments around delayed care related to the perception of staff being more available,
- Staff had sufficient access to pressure relieving equipment such as mattresses and cushions, at all times, or borrowed equipment from other wards if needed.

- Physiotherapists and occupational therapists who ordered equipment from an external company reported they had no problems in accessing equipment which was delivered to the patients home in a timely manner.
- The hospital also had a central store that provided some equipment for patients to take home. Equipment was traceable which meant that patients were protected if a product needed to be recalled, cleaned, or when maintenance and replacement was required.
- We visited the day room on Farley stroke ward and noted furniture such as armchairs and rehabilitation equipment cluttered a corner of the room, which presented a potential trip hazard to patients.
- Each ward and department had a resuscitation trolley containing emergency equipment and medication in the event that a patient suffered a cardiac arrest. Wards kept trolleys secured so that medication did not go missing and could be ready to be use in an emergency. Hospital policy stated that these should be checked daily to ensure reliability and to allow for the replacement of essential equipment. On some wards we found omissions in daily checks. Therefore, there was a lack of assurance that this equipment was fit for use.
- The hospital reported some delays with the turnaround of endoscopy equipment. This related mainly to the length of time needed to decontaminate an endoscope in a safe and compliant manner.

## Medicines

- The hospital maintained an up to date medicines policy designed to safeguard patients and staff from errors relating to medicines. The policy outlined safe practice for the prescribing, ordering, storage, administration, recording and disposal of medicines in the hospital.
- The arrangements for managing medicines kept people safe. Ward staff stored medicines in lockable storage trolleys which were chained to the wall when not in use. Staff used the drug trolleys on ward rounds and administered medication in a safe manner, in line with the hospital's policy.
- The endocrine team raised concerns that there was a significant risk in relation to insulin prescribing. We examined insulin prescribing in a number of patients' medical records and found appropriate insulin prescribing in all cases. A sister we spoke with felt her staff were adequately trained in insulin management and they had good support from the diabetes specialist nurse.

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- Medication, prescribing and insulin errors were significantly lower than the England average and had all improved since the 2012 audit.
- Wards did not have a local intravenous policy and used an externally developed injectable medicines administration guide. We did not identify any local audits of medication practice with injectable medicines.
- The provider conducted audits of antibiotic prescribing at approximately six monthly intervals. This demonstrated a 93.1% compliance with prescribing and appropriate documentation.
- As part of a health improvement project, junior doctors carried out a review to see how they could reduce out of hours prescription errors via access to a new electronic system for on call medical teams. As a result, junior medical staff reported a reduction in errors and improved access to clinical information, such as GP records and prescribing information.
- Staff implemented safety systems, processes and practices and monitored these in order to identify if any improvements were necessary. Ward sisters audited the safe and secure management of medicines using a checklist. Reports identified areas where medicines were not stored and managed effectively. For example, on Farley ward an audit carried out in July 2015 identified that staff left medications out on work surfaces and bags of medications prepared for patients to take home were left on the floor. During the inspection, we found medications were stored safely and in lockable cupboards. Staff kept doors locked and access could only be gained with an electronic swipe key device worn by staff. This practice safeguarded patients from harm.
- Wards provided patients with lockable cupboards for the storage of their own medicines. The acute medical unit (AMU) had a dedicated full time pharmacist working on the ward and a member of the pharmacy team checked medicines that patients brought with them into hospital.
- Staff identified and documented patients' allergies well. We saw the allergy status of patients' recorded appropriately in documentation such as prescription charts and health care records. Patients with a known allergy status wore red wristbands.

## Records

- The trust maintained a record keeping policy that was accessible to staff from the hospital's website. It stated

that all patients must have a nursing assessment completed within six hours of admission to hospital. We did not receive audit data that could confirm whether this was regularly achieved.

- It was noted in the directorate risk register that there were concerns that limited estate capacity made consistent delivery of ambulatory emergency care and assessment of new admissions a challenge.
- Hospital policy stated staff performing care or carrying out treatment should effectively record planned care that had been delivered. This should be documented in the patient's healthcare record at the time of the assessment or treatment. We found that staff did not always maintain accurate and complete patient healthcare records in line with the hospital's policy and best practice. We identified a poor standard of documentation with regard to intravenous cannulas and urethral catheters and the recording of patients' weight.
- When patients were admitted, staff completed individualised care plans and carried out risk assessments. These included for example, identifying any areas of pressure damage to the skin, a nutritional assessment with a patient's weight, appetite and ability to eat. Documenting a patient's weight is important for monitoring their nutritional status and managing their fluid balance, as well as calculating accurate doses of some medicines. Following a medicine departmental meeting, senior staff recorded on the risk register in June 2015, a lack of accuracy of admission documentation. This was attributed to a high volume of admissions and patient acuity. It resulted in gaps in nursing assessments and the recording of patients' weight. Actions to improve practice were put in place. However, during the inspection, we identified that staff were still not routinely documenting patients' weight in their care records.
- The practice of caring for cannula and catheter devices did not always protect patients from the risk of hospital acquired bacteraemias. A nurse we spoke with told us trust wide learning from an MSSA bacteraemia in the previous year meant an additional box was added to the daily nursing management plan in order to record a visual infusion phlebitis (VIP) score. This is a tool recommended by the RCN for monitoring infusion sites. It is used to determine when a catheter should be removed, but was often not completed. Variations in practice related to the documentation of insertion and

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removal of cannulas and catheters. There was no record of ongoing management and staff we spoke with could not access a policy regarding cannulation. We found inconsistencies on wards and between wards. There were at least four different places where cannula insertion could be recorded. The hospital did not have a reliable system to record the length of time a catheter or cannula was in place that did not involve looking back through patients' notes, which were filed daily.

- Across wards, we found many of the forms used for nursing assessment documents and patient records were poor photocopies. This made it difficult to effectively interpret some of the information that appeared in them. For example, the Bristol Stool Chart is a pictorial scale designed to classify faeces into groups. The pictures on the scale were too poor to be able to provide an accurate reference. It was often impossible to see where a document originated or whether it was current, as the date and title had been moved off the page due to repeated copying.
- Patient records were stored securely within the medicine directorate, which maintained patient confidentiality and safety. The hospital provided lockable trolleys to keep patients' records secure. We found trolleys on wards locked and kept secure when not in use.

## Safeguarding

- There were systems, processes and practices in place that kept patients safe which were understood and implemented by staff. The provider maintained a safeguarding policy which identified the roles of key, senior personnel and their responsibilities in ensuring the hospital complied with relevant legal and statutory requirements.
- Staff understood their responsibilities to adhere to safeguarding policies and procedures. We spoke with a variety of clinical and non-clinical staff who told us they felt confident about what constituted a safeguarding concern and able to discuss concerns with more senior staff.
- The hospital provided us with a number of sets of data for safeguarding training it provided to staff annually. Some data only related to five of the eight medical wards, for which training for adult safeguarding demonstrated a high level of compliance of 90.5%, and safeguarding children for clinical staff at 74.3%. Data relating to three wards showed 83.3% of non-clinical

staff received safeguarding training for children. Other data showed 86% staff completed adult safeguarding training, but this included some data from areas other than medical services.

- We reviewed quality and clinical governance reports produced every three months by the medicines directorate. It included safeguarding alerts reported about the hospital. The provider shared learning from this, even when the claim was not upheld.

## Mandatory training

- The trust provided a basic level of information to demonstrate completion of mandatory training that related to a small number of topics, such as infection prevention and control, hand hygiene and safeguarding adults and children. It covered five out of the eight adult inpatient medical wards. This showed 77.8% of staff had completed this training, which was below the trust's target of 85%. It was not possible to comment upon training for topics such as dementia awareness, basic life support, or other topics normally reported on in this section.
- Staff on Winterslow ward told us that mandatory training was 80-85% completed against the hospital's target of 85%. Data provided showed staff on the ward had completed 74.5% of mandatory training in December 2015. Some staff told us completion data was not always reliable or up to date. Some staff told us that despite having completed mandatory training modules, the electronic database still showed modules as not completed.
- Staff received email alerts to alert them when they needed to complete mandatory training modules. A number of staff told us that it was difficult to get the time to access mandatory training modules and so did some of it in their own time.

## Assessing and responding to patient risk

- Healthcare staff performed a range of patient risk assessments in order to identify patients at risk of pressure damage, blood clots, falls and malnutrition.
- The medicine directorate assessed 96.6% of its patients for the risk of a venous thromboembolism (VTE) versus a 96% national average, for April 2014 to March 2015. This meant it protected a high proportion of its patients from dangerous and potentially life threatening blood clots.
- The hospital recently began auditing a combination of data related to falls assessments, accuracy of falls

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assessments and whether intentional rounding was implemented for those identified at risk of falls. Intentional rounding is where health professionals perform regular checks with individual patients at set intervals. Data was collated from July 2015 although not all wards entered audit data systematically or used the same paperwork. Winterslow ward demonstrated more consistent data, and showed that by October 2015, it was risk assessing 83% of its patients, of which audits recorded all were done correctly. Data showed all patients identified at risk of a fall received increased monitoring through intentional rounding.

- The hospital joined the national sign up to safety campaign as part of a programme to reduce avoidable harm. Data published as part of the sign up to safety programme showed falls resulting in injury decreased during between 2011 and the end of 2014. The hospital attributed this to an emphasis on reliable assessment, identification of high risk patients and implementation of intentional rounding as an intervention.
- The hospital reported a good level of recording of pressure ulcers on admission, which ensured they were recorded correctly as hospital acquired, or already in place on admission.
- A medical photographer photographed pressure ulcers on admission and had trained other staff on this process. This ensured accurate recording of pressure ulcers in line with national guidance.
- A Tissue Viability Specialist Nurse led cluster reviews of pressure ulcers to determine causes and learning from incidents. It reported a decrease in grade 2 pressure ulcers in August 2015 with a downward trend since April this year.
- The provider did not have specific training for staff relating to ligature risks. However, it stated that as an organisation it responded to the estates alerts around ligature points and a resource checklist could be used to assess any environmental hazards in the presence of a high risk. This would normally be done in conjunction with the mental health liaison team. Data relating to a risk assessment completed for the AMU was dated October 2006.
- The trust did not ensure that all urgent or unplanned medical admissions were seen and assessed by a consultant within 14 hours of admission. The NHS seven day forum report recommends patients admitted as an emergency should be seen within 14 hours by a consultant. The majority of emergency medical

admissions patients in the UK are admitted through an acute medical assessment unit. Nurses at Salisbury assessed 100% of patients within 30 minutes.

Consultants reviewed 90% of patients within 14 hours and saw all patients within 20 hours. The hospital was therefore not meeting this guideline.

- The National Institute for Health and Care Excellence (NICE) clinical guideline 50 recommends the use of an early warning scoring system (EWSS) to recognise and respond to acute illness or a deteriorating patient in hospital. The hospital used a modified early warning scoring system to monitor changes in a patient's physiology. Staff converted patients' observations into a score and followed an escalation protocol if a patient's score reached a certain threshold. Staff also recorded the patient's oxygen saturation and urine output as part of this monitoring process.
- The hospital had onsite access to levels two and three critical care. Where necessary, patients were referred to the intensive care team or the critical care outreach team to review the patient. The hospital's policy stated that for patients whose scores triggered concern, they were added to the hospital at night handover list and discussed at the meeting. The hospital provided training on EWSS and escalation information aimed at different staff roles during hospital or ward induction. Compliance with the use of EWSS was 96% during the first quarter of 2015, versus a trust target of 95%.
- On Pitton ward there was a respiratory high dependency unit used for patients receiving non-invasive ventilation. These patients had their needs met without needing to be on the intensive care unit. The critical care team gave support and advice regarding these patients.
- When the medical wards were full, the hospital admitted medical patients to other wards outside of medical services, such as surgical wards. These patients are known as medical outliers. Medical outliers received appropriate care and treatment. Staff carried out a clinical assessment to ensure only suitable patients were transferred to another area. Surgical ward staff felt adequately skilled to manage these patients and supported by both medical and surgical doctors to do so. Staff told us that they were always aware of which doctors were providing specialist medical care and treatment to the medical outlier patients and medical consultants reviewed these patients daily. They were confident they had the appropriate staffing levels and skill mix on the ward to manage medical patients



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effectively. They refused to take the patient if they felt they could not give them the right level of care. Several nursing staff on surgical wards described the medical patients they received as the same type of patient without having had surgery. Nursing staff reported that it was easy to access the designated consultant and that medical staff on the surgery wards were happy to treat patients on their wards.

- We observed two safety briefings during the handover of day staff to the evening shift. Ward sisters in charge gave a concise, detailed account of the important issues to highlight to the night staff for their attention. For example, the briefing identified patients at risk of falls, those who were confused or had special nutritional needs. On the acute medical unit, the sister flagged six patients waiting to transfer out to receiving wards and a patient with diabetic ketoacidosis who was ready for admission. This is a potentially life-threatening complication of diabetes and as such, the sister organised one-to-one care for the patient during this shift and cover for the following day.
- During the inspection, we heard the cardiac arrest alarm sound on a ward. Staff of all disciplines from all over the ward attended rapidly to the situation, which turned out to be a false alarm.
- When therapy staffing was lower than demand, they prioritised duties so that they saw new patients first, followed by those patients who needed care to prevent them from deteriorating, and then reviewed patients to facilitate their discharge. These groups of patients took precedence over routine rehabilitation.
- Staff were in the process of auditing compliance with sepsis screening and antibiotic prescribing as part of a national CQUIN (Commissioning for Quality and Innovation) for 2015 to 2016. The most recent data provided related to the period from January to March 2015 in the quarterly stocktake report for the medicine department. It showed a 77% compliance with this CQUIN which was above the trust's target of 65%. Staff we spoke with were aware of the high risks of sepsis and the Sepsis 6 pathway to follow.

## Nursing staffing

- The provider reviewed staffing levels and skill mix regularly and appropriately to ensure people received safe care and treatment, in line with relevant guidance. The provider used an electronic rostering system for nurse staffing which the medical directorate senior

nurse oversaw. It was one of the 22 trusts under the Lord Carter scheme, which is looking at acuity data for the Department of Health. This system uses a model to measure patient acuity. Staff entered information three times per day. Senior leaders collaborated with other trusts that had used this tool and believed inputting data this frequently would enable them to have the most accurate acuity data. The trust recently began reviewing this data to ensure its accuracy.

- The Director of Nursing and Deputy Director of Nursing carried out six monthly skill mix reviews with the Directorate Senior Nurse and each ward manager. This ensured consistency and compliance with NICE standards. The most recent skill mix review was completed in September 2015. Senior management approved an increase in the number of nurses on Redlynch and Pitton wards at weekends on a six month pilot, in October 2015.
- Whiteparish ward was the acute medical assessment unit. The directorate planned a further skill mix review, subject to the outcome of a pending business case to relocate this unit. A further skill mix review was planned for Durrington ward following the full implementation of the rapid access care of the elderly model. Winterslow ward planned a reduction in their band five establishment by four whole time equivalent staff who were to be replaced with band fours (trainees in post) due to vacancies that were continuously experienced.
- Directorate senior nursing staff visited each ward daily in order to check staffing levels by looking at the skill mix and bed occupancy. They sometimes moved staff between wards or to another directorate, or deployed bank and agency staff to fill any gaps in the shift.
- We attended four bed management meetings which took place twice and sometimes three times a day. Within this meeting senior staff gave an update of current staffing levels to establish bank and agency staffing requirements. A bank and agency coordinator attended and immediately acted on this information.
- Staff on wards felt they had adequate access to bank and agency staffing when needed. A senior ward nurse said they did not feel too pressured and the trust could access bank staff who were appropriately trained.
- Planned staffing levels were comparable to actual staffing levels. The trust provided data which showed

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the nursing and nursing assistant shift fill rates for the months of May to August 2015. All eight of the medical wards were given a rag rating of green, which was awarded for a greater than 80% fill rate.

- We visited the trust during the day, evening and at the weekend and found staffing ratios fell within the recommended ratios for safe patient care. Patients told us there were sufficient staff on the wards in order to meet their care and treatment needs.
- Wards remained compliant with nationally recommended ratio of one nurse to eight patients. The ratios of registered nurses to nurse assistants differed from ward to ward depending on the care needs of patients. The supervisory ward sister or charge nurse role was supernumerary.
- Staff on the acute medical unit told us they often finished after their allocated shift time and did not always get breaks. Staff often had to take patients on this ward for tests or move beds, and felt nursing assistants frequently acted as porters.
- Staff commented beds never closed due to a shortage of staff, as they could pull staff in from other wards. The hospital site management team stepped in to help if needed, and the hospital outreach team could be contacted for assistance to ensure the safe care of patients on the wards.
- Arrangements for handovers and shift changes maintained patient safety. During the safety briefing that took place during a shift handover, we saw how ward sisters delegated staff with tasks according to skill set, patient risk and acuity.
- Agency staff completed a ward orientation induction prior to starting work on the ward and a record of this was kept on file within the trust. Agency staff told us they felt supported to carry out their role on the ward. Agency and bank staff could be booked in advance to provide consistency to the ward staff and to patients.

## Medical staffing

- Medical staffing levels and skill mix was planned so that patients received safe care and treatment in line with guidance. Guidance from the Society for Acute Medicine and the West Midlands Quality Review Service (2012) suggested that a consultant should be on site or be able to reach the acute medical unit within 30 minutes. Staff confirmed that they had access to an on call consultant rota and that they were able to contact a consultant at all times for support and guidance.

- Physicians and surgeons provided care for medical patients outlying on surgical wards. Patients had a named consultant who visited them on the wards daily. Nursing staff felt supported by consultants in caring for these patients. Boards at the patients' bedside identified the consultant and nurse in charge of their care.
- The hospital at night team within the medicine directorate consisted of a coordinator, junior and middle grade doctors.
- The medical assessment unit (AMU) consultants reviewed all patients within a set time scale in accordance with the initial triage assessment. Urgent patients classed as 'red' were seen within 30 minutes, amber 60 minutes and green within four hours. During out of hours, consultants aimed to review patients within 14 hours. AMU consultants were available between 09:00 -19:00. A medical consultant covered the on call hours between 17:00-09:00, which included 17:00-20:00 for MAU admissions, the 08:00 ward round and were contactable for advice or to come in between the hours of 20:00-08:00.
- Two general medical consultants covered weekends and bank holidays. Other on call cover was for haematology ward rounds during weekend mornings. Cardiology had 24 hour seven day cover with a formal ward round on Saturdays and Sundays, although not all patients were reviewed. Those who were sick, admitted to AMU and those waiting for discharge were seen over the weekend.
- The AMU held a board round daily which included the consultant, junior doctors and nursing staff. A detailed handover regarding each patient took place for each nursing bay. During daily safety briefings patients were prioritised for a visit from a consultant.
- Patients told us they felt safe and well looked after and they saw a doctor regularly.

## Major incident awareness and training

- The hospital had a major incident policy which could be accessed through its website. Some staff were aware of the major incident policy and procedure but told us they had not practiced this for some time. The policy was under review at the time of the inspection.
- The plan outlined roles and responsibilities for all staff, designated a control room within the orthopaedic department.



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- To enable the hospital to manage winter pressures, an additional ward opened for several months in January of each year.

## Are medical care services effective?

Good



Patients received effective care and treatment. Staff delivered care in accordance with evidenced-based guidelines and current best practice. Patients' pain was well managed by staff in the hospital and feedback from patients reflected this.

The hospital participated in local and national clinical audits and information was shared internally and externally in order to improve care and treatment. The majority of patient outcome data for the hospital showed a performance in line with, or better than the national average.

Medical staff were having regular appraisals. However, although nursing staff reported they had received an appraisal in the last 12 months the data provided by the trust showed only 40% of its nursing staff had received an appraisal in the last twelve months.

There was good multidisciplinary working between wards and departments in the hospital and all relevant staff and departments were involved in assessing, planning and delivering people's care and treatment in order to meet patients' needs.

### Evidence-based care and treatment

- The hospital kept a wide range of policies and procedures accessible to staff on the intranet. It reviewed policies and procedures to align them with guidance provided by the National Institute of Care Excellence (NICE) and other expert professional bodies.
- The inpatient diabetes team continually reviewed and developed protocols and management guidelines in line with best practice. Specialists recently developed a chart for the management of diabetic ketoacidosis, a potentially life-threatening complication of diabetes. This was instigated following an audit which suggested variations in compliance with a previous care pathway.
- The diabetes inpatient foot care service reported it was unable to meet the current NICE guideline and quality

standard consistently and especially at weekends. The standard requires diabetic foot patients are reviewed by a multidisciplinary team within 24 hours of admission to the hospital.

- The hospital's endoscopy service held accreditation through the Joint Advisory Group (JAG) for gastrointestinal endoscopy. Endoscopy records were fed into national surveys through the JAG accreditation system. This accreditation demonstrated the effectiveness of its endoscopy service.
- The hospital provided a stroke pathway for all patients presumed to have had a stroke or transient ischaemic attack. This is a mini stroke, caused by a temporary disruption of blood supply to the brain. Farley stroke unit received all stroke patients referred directly from their GP or the emergency department 24 hours a day, seven days a week.
- Consultants reviewed patients on medical wards on a daily basis Monday to Friday and some patients over the weekend where it was deemed necessary.
- Cardiologists provided evidence to show how they had remained up to date with best practice, and reviewed and implemented up to date guidelines by incorporating this into educational presentations.

### Nutrition and hydration

- The hospital's food and nutrition policy and practice was overseen by the trust's food and nutrition group.
- The hospital enforced a policy of protected mealtimes so that patients' meals were not interrupted by procedures or assessments unless urgent. Ward managers ensured activities during mealtimes focused on the service of food and staff provided patients with appropriate assistance with meals.
- A food and nutrition mid-year report in August 2015 showed 93% of patients had their dietary requirements documented. This included a reference to the type of diet the patient wanted, for example, diabetic, vegetarian or vegan. Staff also documented mouth and dental assessments.
- Speech and language therapists and specifically trained carried out swallow assessments within four hours of admission. This was a recognised target within a national stroke audit.
- Staff carried out nutritional screening on admission and during subsequent assessments, then documented actions to reduce the risk to patients. Hospital policy stated all patients should be weighed on admission and

# Medical care (including older people's care)

during re-assessment. In September 2015, the trust re-assessed NICE quality standard 24 for nutrition support in adults and judged it partially met. The use of a validated nutritional screening tool achieved a 98% compliance. However, the trust documented a concern with the recording of patients' weight, as only 34% of patients had weight recorded.

## Pain relief

- The hospital's nursing assessment policy stated a patient's pain should be assessed within six hours of being admitted and after each set of cardiovascular observations. We saw evidence of pain assessments within nursing records and these were in line with policy.
- Pain relief on medical wards was well managed, including for patients with difficulties in communicating. Staff used a pain assessment to chart the causes and characteristics of the pain, and used a scale of one to ten to document the patient's current perception of pain.
- Patients told us and we observed staff ask if they were in any pain and medicines were administered to those who needed it.
- For patients who were less able to communicate verbally, staff explained how they would use facial expression, changes in mood and other non-verbal cues to assess pain. On Durrington ward, staff trialled a new pain assessment form for such patients to see if this could provide an even more accurate reflection of the patients' level of pain. Staff spoke with relatives or used documentation such as the 'this is me' dementia document, so they were more likely to recognise any change in the patients' level of pain.
- Staff accessed an on-site pain team for further assistance and advice where necessary, in order to meet the patients' needs.
- Inpatient feedback about pain management on the wards as part of the trusts 'real time feedback' programme showed pain was well managed with average scores reaching almost ten out of ten.

## Patient outcomes

- The hospital regularly monitored outcome data in relation to patients' care and treatment. The majority of patient outcome data for the hospital showed a performance in line with the national average or better.

- The trust regularly reviewed the effectiveness of its care and treatment through local and national audit and acted upon the information. The hospital contributed to a national audit plan which where appropriate followed NICE guidelines. National audits such as; chronic heart failure, chronic kidney disease, diabetes in adults, acute kidney injury, and acute upper gastrointestinal bleeding were used to develop services and improve patient outcomes. For example, the hospital's stroke services achieved an overall rating of 'B' in the June 2014 to July 2015 sentinel stroke national audit programme. A was the highest score relating to occupational therapy input into stroke patient care, and E was the lowest score which related to speech and language therapy input. There was an action plan in place to address the lower performing score.
- The medical director reported good performance with stroke care in the October 2015 quality indicator report. Stroke patients spent 90% of their time on the stroke unit versus a target of 80%.
- The NICE guidelines recommend the measurement and documentation of the surface area of pressure ulcers. A medical photographer photographed pressure ulcer wounds when the patient arrived at the hospital to ensure the effective monitoring of pressure sore healing. One patient told us how they had arrived at the hospital with a pressure sore, which healed well under the care of the hospital. "The wound has improved considerably under the hospital's care and has almost healed."
- The standardised relative risk of an elective patient readmission for the trust was 96 and for non-elective re-admissions it was 90. A value of less than the England average of 100 was positive, as it meant the patient was less likely to be re-admitted.
- The hospital achieved good patient outcomes in the national heart failure audit with inpatient hospital care achieving as good as, or above the England average score. These four scores included: input from a specialist, input from a consultant cardiologist, cardiology inpatient care and whether the patient had received an echocardiogram (a test used in diagnosing heart disease).
- The myocardial ischaemia national audit project (MINAP) is a national clinical audit of the management of heart attacks. The hospital performed better than the England average across all parameters in this audit which related to care of patients with non-ST-elevation (nSTEMI) infarction.

# Medical care (including older people's care)

- The hospital performed better than the England average in 11 out of 20 parameters of the national diabetes inpatient audit. Some areas in particular performed significantly better than the England average. For example, patients visited by a specialist diabetes team achieved 96.7% versus the England average of 34.7%. Poorer performing areas related to staff knowledge and the timing and suitability of meals. The hospital's endoscopy service held accreditation through the Joint Advisory Group (JAG) for gastrointestinal endoscopy. This accreditation was achieved because the hospital demonstrated a range of standards including, quality, effectiveness and safety.

## Competent staff

- The appraisal of doctors and consultants within the directorate was 84% and the remaining appraisals were under review. Appraisals for non-medical staff within the wider medical directorate was 52%. We did not receive data for this group which was specific to adult inpatient medicine which is the focus of this report. In April 2014 the trust introduced a new electronic appraisal system for non-medical staffing. The trust informed us that during the transition to this system it experienced some issues with non-medical staffing data.
- The trust did not have adequate arrangements in place to support and manage nursing staff through appraisals. Nursing staff we spoke with who had received an appraisal during the year spoke highly of the process. However, the trust reported that only 40% of its nursing staff had received an appraisal in the last twelve months.
- The medical directorate did not include bank staff in its appraisal system as it classed them as temporary workers, not employees. As such, they only received an annual review
- The majority of nursing staff we spoke with felt they had received sufficient training to perform their role and that they were able to access further role specific training if required. For example, a nurse on the stroke ward we spoke with received role specific training relating to naso-gastric tube insertion and swallow assessment competencies, and was given permission to attend further training.
- On one evening during the inspection two members of agency staff were allocated to a night shift on the acute medical unit. Staff told us they lacked some common competencies that made them less able to support staff

in the management of patients on the ward. For example, they lacked skills in venepuncture and cannulation. These are essential procedures to aid the monitoring and diagnosis of a patient's condition and are one of the most common procedures in hospitals.

- The coronary care ward, Tisbury, reported in November 2015 it experienced difficulties in the recruitment of experienced nursing staff. However, training was put in place for the 12 band five nurses which included cardiology specific education. Management ensured a senior nurse was rostered on the ward at all times for newer nurses to go to if they needed support.
- Some staff informed us the trust had provided them with opportunities for further development. For example, one member of staff explained how they secured funding for university accredited training through an application to the trust with the support of ward management. A number of nurses we spoke with had accessed further training specific to their role, such as intravenous cannulation. They felt they could approach seniors for further training if needed.
- Nursing staff recruited from overseas felt supported by their colleagues. Some of these nurses were also newly qualified and told us more experienced nurses, nursing assistants and medical staff on the wards supported them to become competent quickly. After an induction programme, overseas nurses worked as supernumerary staff for six to eight weeks and longer if needed.
- Staff knowledge was identified as a concern within the national diabetes audit. We spoke with staff on the ward who informed us that there was only one diabetes specialist nurse, leaving a gap in the service when not on duty and little resilience in the service.
- Some nursing assistants we spoke with told us they had a higher level of skills than their grading and felt frustrated they were unable to employ these skills and work at a higher grade.
- Trainee doctors told us they felt supported by more senior peers and were provided with opportunities to learn from them.

## Multidisciplinary working

- We saw evidence of good multidisciplinary working between wards and departments in the hospital. All necessary staff from a variety of teams were involved in assessing, planning and delivering people's care and treatment.

# Medical care (including older people's care)

- A broad spectrum of staff on AMU worked together to coordinate the patients onward care in the hospital and for their discharge. These included consultants, doctors, nurses, pharmacists, nursing assistants, physiotherapists, occupational therapists, social workers, the access to care team, administrators and domestic staff. Daily board rounds took place where details of patients admitted were displayed on a board and a multidisciplinary team discussed and coordinated their care collectively.
- Staff worked together to assess and plan ongoing care when people were due to move between teams and services. A discharge coordinator worked on every ward and we observed multidisciplinary team meetings and saw actions taken which worked towards the patients' discharge. For example, staff coordinated tests and assessments, the care delivered to patients and organised medications with pharmacists to ensure patients were ready to go home.
- Patients told us that they felt their care was well coordinated in the hospital. Staff worked well to coordinate care between internal departments and offered timely access to services such as physiotherapy and occupational therapists. Therapy staff coordinated onward care for patients by liaising with carers, families and community therapy staff to assess the patient's environment at home. Therapists carried out home visits if needed to make an assessment of the patients home environment. This made it less likely the patient would be readmitted.
- Physiotherapists and occupational therapists coordinated therapy support across all wards within the medicine directorate. They met in the mornings to discuss and prioritise their patient caseload and to distribute work accordingly.
- Staff on Tisbury ward raised a concern that the number of patients with a tracheostomy on the ward sometimes increased. Staff accessed support by contacting the directorate senior nurses or the critical care outreach team when needed.
- Therapy staff worked closely with elderly care wards, dementia leads on the wards and attended weekly multidisciplinary team meetings.
- The diabetes team admitted patients with diabetic foot problems as their primary reason for admission to a medical ward, but worked closely with the foot team to ensure they were seen as part of their weekly ward round or when required. This team included a surgeon, podiatrist and microbiologist, with input from orthotics where needed.
- The provider had a close working relationship with a number of hospitals and community hospitals within a 20 mile radius. For example, a consultant told us how he had taken a patient to the emergency department because they had developed chest pain whilst under their care. The patient was transferred to Southampton hospital that evening due to the rapid review and transfer process within the hospital.
- The trust worked with its community partners where possible to enable early supported discharge. For example, some stroke patients were discharged earlier as staff coordinated care within the community for rehabilitation to continue at the patients' home, so they spent less time in hospital.
- Durrington ward was established as rapid access care of the elderly ward which aimed to treat and discharge patients within five days. The ward admitted patients from the acute medical unit (AMU), the short stay emergency unit, and occasionally directly from clinic. The ward aimed to offer an immediate, comprehensive, geriatric assessment through a daily multidisciplinary team meeting structure, and by working with community and social work in-reach teams. Clinicians used an 'access to care' screening tool to coordinate care with different services within the locality.
- Cardiologists had regular multidisciplinary team meetings and linked with Southampton hospital to discuss patient cases and shared learning by linking presentations screens via the internet.

## Seven-day services

- In December 2014 the trust held a review of its seven day services in which clinical assessment by a suitable consultant within 14 hours, seven days a week was considered a priority. The trust was in the process of implementing a range of innovations to assess and monitor this and in order to make effective changes. Plans for seven day working were on going at the time of our inspection.
- Patients in the hospital had access to a number of diagnostic services, some of which were accessed through arrangements with neighbouring hospitals.

# Medical care (including older people's care)

- The trust worked with Royal Bournemouth and Christchurch Hospitals, to provide on call rotas in stroke and vascular services. Arrangements were also in place to provide joint care for some patients who required interventional cardiology.
- The Stroke Network ensured 24 hour seven day cover with emergency transient ischaemic attacks (TIA) clinics running every weekend, with one in three being at Salisbury District Hospital and the others at Royal Bournemouth and Christchurch Hospital and Poole Hospital. Arrangements were also in place to provide joint care for some patients who required interventional cardiology. Stroke consultants carried out ward rounds at 9am and 5pm Monday to Friday within the hospital and a general physician was available out of hours. The trust was trying to recruit a third consultant at the time of the inspection.
- The hospital provided a service for percutaneous coronary intervention (PCI) during Monday to Friday from 8am to 5pm. This is a non-surgical procedure used for treating the narrowing of the arteries of the heart found in heart disease. Outside of these times, out of hours care took patients to either Bournemouth or Southampton hospitals.
- The pharmacy provision was from 9am to 5pm on the acute medical unit, 9am to 12pm on Saturday and there was access to some medicines on a Sunday. Pharmacy technicians had laminated a specific out of hour's protocol for nurses to use for dispensing medication.
- Pathology, blood and diagnostic services such as X-ray and computerised tomography (CT) scans were available over seven days.
- A mental health liaison team saw patients between 9am and 5pm, seven days a week.
- The trust employed one diabetic specialist nurse who worked across the wards. This left a gap in the service at weekends, but the directorate organised cover during annual leave.
- Therapy services were available over seven days to the general inpatient areas Monday to Friday and from 08.45-12.30 on a Saturday and Sunday. Therapy services ensured an overnight rota for respiratory physiotherapy was in place. This meant that patients with respiratory problems were supported during the night and could be cared for on the ward, rather than being moved to the critical care unit.
- All the information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way. Patient records were accessible to staff and were generally well managed. Records were paper based and were either archived when they were not in use, kept with the consultant, in the clinical area or in locked trolleys. A ward clerk confirmed 75% of notes arrived with the patient on entering the ward or were received within 24 hours.
- Access to patients' diagnostic and screening tests was good. Staff in the acute medical unit reported blood results were available within one and a quarter hours and chest X-ray reports within one hour.
- GPs could talk to consultants on AMU directly via a dedicated phone line giving them direct access to information about their patients.
- The hospital's intranet site ICID: Integrated Clinical Information Database had a wide range of information accessible to staff and the public. Policies, documents and clinical guidance were accessed through the search function.

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

- The hospital policy outlined the reason, legal framework and processes for gaining a patient's consent to care and assessing a patient's mental capacity where appropriate. Staff filled in a specific form for use with patients who did not have mental capacity. It identified how the clinician had come to the decision and where other parties, such as close relatives and carers were involved in making decisions in the patient's best interests.
- Data provided to us by the trust, which included some staff outside of medical services showed 68% staff completed mental capacity training and 86% of staff were trained in safeguarding adults.
- Staff had a good understanding of Deprivation of Liberty Safeguards (DoLS). Guidance on the trust's internet provided clear steps for the decision making process to follow when considering a DoLS application and we saw this implemented well. For example, on Winterslow ward staff carried out DoLS assessments for three patients, two of whom required a DoLS. These were completed appropriately however, both had expired.

## **Access to information**



# Medical care (including older people's care)

- The trust commented in a recent report that very few DoLS applications had led to a "Best Interests" meeting and as a result, this was followed up by hospital staff visiting the local authority to discuss.
- We observed and patients told us staff attending to their healthcare needs sought verbal consent before a procedure or treatment.

## Are medical care services caring?

Good



Caring for patients in the medical services was rated as good. Feedback from patients about the care they received at Salisbury hospital was positive. Staff treated patients with dignity, kindness and respect. We heard call bells being answered quickly and call bell audits reflected this.

Staff were updated on a regular basis with patient feedback about their experience of care and treatment at the hospital and we saw evidence of staff learning from this to improve care.

Staff engaged with families and carers about the patients' care and treatment in the hospital and in managing their discharge and ongoing care.

Patients felt involved and informed in decisions made about their care. Their choices and preferences were taken into account when staff planned their care and treatment. Staff communicated effectively with patients, in a way they could understand.

### Compassionate care

- Staff on medical wards treated patients with kindness, dignity and respect. Patients told us they received a good standard of medical care and had the opportunity to discuss their care with their doctor or consultant regularly.
- Staff treated patients in a manner that maintained their dignity. On most occasions, we saw staff ensuring curtains were drawn when carrying out personal care. However, on one occasion, we saw staff removing a cannula in front of visitors at the patient's bedside.
- We heard staff seeking permission as to how the patient preferred to be addressed and staff spoke in a kind and respectful manner.

- In the patient led assessments of the care environment (PLACE) 2015, the hospital scored 89.5% for privacy, dignity and wellbeing. The England average score was 86%.
- The trust collected its own feedback called 'real time feedback' by talking to inpatients across all wards on a monthly basis. Some areas of concern in 2015 included call bells not being answered. During the inspection, staff answered call bells promptly and we observed call bells were within patients' reach. An audit of call bell response times across three days in October 2015 showed that on average staff answered over 70% of call bells in less than four minutes.
- Real time feedback showed patients felt they were treated with care and compassion. Patients gave this an average score of just under ten out of ten.
- The medical directorate used the Friends and Family test to seek feedback about the patients' experience in the hospital. Data was provided from individual wards. The average response rate in England between July 2014 and June 2015 was 34.5% and for the trust was 34.4%. The response rate varied between wards for the period of time between August 2015 to October 2015 with between 12% and 44% of patients responding. The highest patient response came from Redlynch ward in October and the lowest response rate was from Farley ward in the same month. Patient satisfaction varied from month to month and ward to ward but was generally at a high level. The acute medical unit consistently had slightly lower scores, but were still positive.
- Staff received friends and family test feedback every couple of weeks by email in order to learn from patients' feedback.
- On some wards, staff displayed comments of thanks from patients which talked about the care they had received and the kindness of the staff on the wards. Patients we spoke with were also complimentary about the nursing and nursing assistant staff in particular, saying that nothing was too much trouble and they had been well looked after during their stay. We saw a number of compliments which had been sent by patients to the customer care team. These examples talked about the care and compassion patients experienced directly or was observed by carers and relatives of patients treated in the hospital.

# Medical care (including older people's care)

- A patient we spoke with commented positively about the friendliness of staff: "If you asked for something, it was done straight away".
- We saw staff rubbing hand cream into patients' hands, applying makeup to patients who valued this and heard them talk affectionately about patients within their care.
- During the inspection a relative on a ward whose father had just passed away, approached us to tell us about the care they had received. They said, "The care and support staff gave us was excellent and we could not have wished for more".

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

- We heard staff communicating with patients and relatives with respect and in a way they could understand.
- Handovers at the patients' bedside kept the patient involved in the discussions about their care and relatives and visitors were included in these discussions where appropriate. During the inspection, we saw staff explaining treatment to both patients and visitors. Relatives told us they had the opportunity to ask questions and raise concerns about the patient's care if they needed. They told us they could phone the ward and speak to someone about the patient if needed, especially if they were worried or anxious.
- Patients and their relatives informed us staff discussed the patients' needs, care and treatment with them. Staff consulted with families and carers to understand the onward care needs of the patient once they were discharged.
- Staff recognised where people who used the service needed additional help and support in order to involve them in the decisions about their care and treatment. For example, staff supported a patient who had just been admitted and who was unable to communicate verbally, by helping the patient to use a pen and paper. They liaised with the patient's family so they could bring in appropriate communication aids that the patient was familiar with.

## Emotional support

- The hospice at the hospital had a pet as therapy PAT dog and patients on medical wards had access to support from this service. PAT dogs can help patients feel calm, happy and bring joy to patients being cared for in hospital. Staff reported patients who were unable

to communicate easily really benefitted from the resident pat dog. For example, a patient who had suffered a stroke and was distressed became visibly calmer after spending time with the pat dog.

- The hospital on occasion allowed patients' pets to come into the hospital which staff reported was of great benefit to patients' emotional wellbeing.
- Qualified volunteers provided complimentary therapies to patients such as aromatherapy, reflexology, massage and Indian head massage to help patients relax, sleep better, and feel better at a difficult time.
- An ecumenical chaplaincy team was available during working hours and on call 24 hours a day throughout the year. The chapel was open to people of all faiths or none and regular services were advertised on notice boards throughout the trust. Visits from the chaplain were arranged for patients and visitors on the wards.

## Are medical care services responsive?

Requires improvement



We found medical services required improvement.

The limited bed capacity, particularly in the acute medical unit, along with recent high bed occupancy levels affected the hospital's patient flow. Some matters outside of the hospital's control also affect this, such the lack of availability of care in the community. The process for discharging patients was not always managed effectively within the directorate. This meant the hospital was not always able to deliver same sex accommodation, although an action plan was developed in August 2015 which aimed to address this. Medical patients were regularly cared for on surgical wards, but with processes in place to ensure their safe care. Some patients were moved during their stay, of which some were moved at night.

The hospital provided a suitable environment and a good level of care for patients living with dementia.

Staff were familiar with the complaints process and knew how to escalate a patient or relatives concern.

Complaints and concerns were responded to appropriately by the trust and staff received learning and feedback from complaints.



# Medical care (including older people's care)

On the whole, referral to treatment times were above the England average which meant patients accessed care and treatment in a timely way.

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

- The acute medical unit (AMU) also known as Whiteparish ward provided rapid assessment, investigation, diagnosis, and treatment for adult patients over the age of 16. GPs had a dedicated phone number for AMU, and consultants liaised with GPs prior to the patient being admitted. Patients received care and examinations in a private trolley area and then returned to a seated area if well enough to do so. A consultant decided if patients went home or admitted them to the hospital for further care and treatment. A multidisciplinary team operated within the department made up of medical staff, nurses, pharmacists, physiotherapists, occupational therapists, domestic and clerical staff. The AMU, was open 24 hours all year round. Patients were clinically triaged using a set criteria. GP's referrals accounted for approximately 40% of patients who attend the AMU, 40% arrived via the emergency department and 20% from elsewhere in the community. There were 21 beds within the unit including three single rooms and four ambulatory care trolleys. The 18 beds were divided between three bays.
- Each year an additional escalation ward was opened to manage winter pressures, usually from January for several months. Staffing for this ward was organised well in advance using staff from existing wards and their positions were backfilled. The medicine directorate used the opening of the ward in January 2015 as an opportunity to test ward-based medical teams and to trial a new 'triage to speciality model'. This meant that wards in the hospital became more specialised as staff could develop specific skills to care for patients with the same medical conditions who were grouped onto the same wards. National Institute for Health and Care Excellence guidelines for a broad range of different respiratory conditions recommended patients are cared for on a specialist respiratory ward. The clinical lead for respiratory medicine reported in March 2015 that ward remodelling resulted in Pitton ward becoming a specialist respiratory ward in January 2015. The number of respiratory patients on the ward increased from 41% to 70%. The spread of respiratory patients across multiple wards also reduced.
- The endoscopy service operated five days a week at the time of the inspection. It began an ad-hoc 'Super Saturday' model in September 2015 for endoscopic procedures. This is a consultant led service and had been run on one Saturday at the time of our inspection. A nurse rota for this was in place but staff told us there was no consultant support. One super Saturday had taken place at the time of our inspection.
- In the July 2015 mortality working group minutes, a clinician raised concerns about the lack of formal gastrointestinal (GI) bleed rota and referred to a new recommendation that patients with any acute GI bleed should only be admitted to hospitals with round the clock access to endoscopy and interventional radiology or a local network arrangement. The provider outlined in this meeting, it needed to develop a network arrangement for interventional radiology due to an imminent vacancy and an inability to recruit for the post. However, interventional radiology was available at the time of our inspection.

## **Access and flow**

- The bed management team (the team made up of professionals involved in ward management, bank and agency staff management, infection control and housekeeping) met two to three times a day to manage access and flow through the hospital. We attended four of these meetings during the inspection. During the bed management meetings, the team reviewed admissions and discharge numbers, the current bed occupancy position, the number of medical patients admitted to surgical wards, mixed sex accommodation breaches and staffing or cleaning issues on the wards.
- Access and flow within the hospital was not always managed effectively. At times, limited capacity affected the hospital's flow and its ability to deliver same sex accommodation. This resulted in unjustifiable breaches of mixed sex accommodation, according to the trust's policy for eliminating mixed sex accommodation. Furthermore, in order to improve flow through the hospital, patients were moved a number of times during their stay, sometimes after 10pm at night. According to the trust's policy, ward moves after 10 pm at night should be exceptional. During a 4pm bed management meeting, staff flagged six patients as being ready to move from AMU to a ward by 6pm that evening. We followed the pathway of these patients and found that staff only moved one of these patients before 10pm, at

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8.35pm that evening. Staff moved the remaining five patients after 10pm, at 22.44pm, 23.00pm, 23.26pm, 00.30pm and 03.07pm respectively. We attended the bed management meeting the following morning and found that despite staff having ensured patients were ready to move by 6pm, there was no challenge between the wards as to why this had not occurred.

- Bed moves affected over a fifth of patients at the hospital between September 2014 and August 2015. During March to July 2015 approximately 150 patients were moved after 22:00 hours of which two thirds were from the acute medical unit. In the previous 12 months to September 2015, there were 979 mixed sex breaches, of which just over a fifth related to non-clinical breaches. A number of patients we spoke with said they had experienced a bed move and were sometimes moved at night. Some patients had complained about the noise at night within the hospital, relating some of this to patients being moved. Senior medical staff from AMU confirmed that staff moved patients at night. Of the total patients admitted in the previous 12 months 16% had one bed move, 5% had either two or three bed moves. A total of 12 patients had four or more bed moves.
- The average occupancy rate for all NHS beds open overnight was 85.7% in quarter two 2015, ending in September. Research suggests that bed occupancy rates greater than 85% can increase the risk of harm including hospital acquired infections and it can start to affect the quality of care provided to patients and the orderly running of the hospital. During the period from June 2015 to November 2015, the hospital's bed occupancy rate was on average 96%. Senior staff confirmed that bed occupancy was generally near 100%.
- Senior AMU staff expressed concerns relating to the limited estate capacity. It was felt this made consistent delivery of ambulatory emergency care and assessment of new admissions difficult. AMU meeting minutes documented concerns relating to frequent delays which had the potential to cause both a clinical risk and a corporate risk, due to increased admissions and poorer flow. At the time of the inspection, senior leadership staff told us about the plans submitted in September 2015, for a business case to relocate the AMU which would lead to an increase in assessment capacity. A decision on this was not made by the time we inspected the hospital.
- In the medicine directorate's October 2015 meeting minutes, it stated single sex accommodation was both a challenge and a big concern for clinician's in the directorate. NHS policies outline a clear commitment to privacy and dignity, stating that same-sex accommodation can dramatically improve how patients feel about their care. The hospital had a policy for eliminating mixed sex accommodation in which it made clear its intention to avoid breaches. This document was aligned to NHS policy.
- Feedback from the executive led safety and quality walk rounds to AMU in November 2015 raised concerns that achieving single sex accommodation caused patients to be cared for on wards other than their medical speciality needs and could impact their treatment and length of stay. When there was sufficient capacity within the trust and on AMU, the hospital reported that inappropriate moves and mixed sex accommodation breaches did not occur. The trust formulated an action plan to reduce non-clinically justifiable mixed-sex accommodation breaches in August 2015. One of the actions that was overdue related to a business case submitted to redesign the patient bays within AMU. The deadline for this was in September 2015 and a decision had not been reached by the time of our inspection. In November 2015 the trust reported only one non-clinical mixed sex accommodation breach occurred, which was an improvement.
- Senior staff visited other acute medical units in different hospitals to understand how to manage this issue better. The hospital had assured the Clinical Commissioning Group (CCG) of its board and director level engagement to resolve mixed-sex accommodation breaches. However, the CCG in September 2015 reported they were unable to gain assurance that patients would not be subjected to unjustifiable breaches in mixed-sex accommodation until the action plan was agreed. Senior leadership within the directorate stated flow was the main cause of single sex breaches although a breach was a last resort.
- On one day of the inspection, there were eight medical outliers and 13 on the previous day. Senior staff in the directorate reported the highest number of outliers as 30 in one day, within the last 12 months. All outliers were risk assessed and patients with specialised needs

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were only treated on the speciality ward. Senior leadership confirmed outlying patients happened on wards all year round. The discharge team visited medical outliers daily.

- Durrington ward provided rapid access to care and treatment for frail and elderly patients and aimed to treat and discharge patients within five days. A consultant from the ward felt that discharge could be improved if they had better links with community teams.
- The process for discharging patients was not always managed effectively within the division. Policy stated beds must be declared to the clinical site team immediately once vacated and the discharge lounge used whenever possible to ensure that once a patient was ready for discharge the bed can be made available. The discharge lounge was open from Monday to Friday from 8.30am to 5pm. Patients who needed to use the transport service to get home needed to allow a four hour window from the time of booking. This meant patients needed to be admitted to the discharge lounge by 1pm in order to meet this timescale. During our inspection we heard numerous examples of issues with the transport company which resulted in delays to patients being discharged and caused distress to patients waiting to leave the hospital. The trust reported it had raised concerns about delays with patient transport with the clinical commissioning group. During a bed management meeting we spoke with sisters in charge of wards who confirmed that there did not seem to be a deadline for discharges to be planned and actioned by and the discharge lounge was not being effectively utilised. Bed management staff confirmed it was very likely that at the 4 pm bed meeting, patients waiting to be transferred to a ward who were flagged in the morning, would still be on the ward. There seemed to be limited urgency or accountability for this.
- Senior medical staff attributed the main cause of delays to patients being discharged to the lack of care in the community.
- Patients told us different teams within the hospital arranged for them to be discharged effectively, with the right care package and equipment in place to be able to return home safely. One patient told us how they felt safe in the hospital and would now feel safe at home. Staff had organised a new bed and hoist, and for carers to visit the patient once at home.
- Gastroenterology consultants confirmed waiting times for a range of gastroenterology and endoscopy

procedures fell well under the 18 week waiting time. For example, oesophago-gastro duodenoscopy the wait was four weeks, flexible sigmoidoscopy was a two to three week wait and colonoscopy was a six week wait.

- The hospital achieved a cancer referral two week waiting time RAG rating of green during 2014 to 2015 and ensured it saw 94.7% of its patients within this time scale. Cancer waits at 31 and 62 days were met.
- The national operational standard for referral to treatment times states that 92% of admitted patients should commence consultant led treatment within 18 weeks of referral. Data relating to October 2015 showed 92.3% of NHS hospitals achieved this. The hospital exceeded the threshold for gastroenterology (94.1%), Cardiology (97.3%), Geriatric medicine (98.5%), and rheumatology (99.5%). Data for neurology was not available.

## Meeting people's individual needs

- The customer care team provided access to trained interpreters to support communication with patients who were non-English speakers or for people for whom English was a second language. It provided services for sign language, the deaf, blind or partially sighted. Ward and departments booked appointments for patients and staff could access a 24 hour telephone interpreting service for emergency situations or short non-complex appointments.
- Some staff located information about the translation service via the intranet, although not all staff were familiar with how to access the service.
- Staff told us that management sent out hospital-wide emails to seek immediate help from staff who could speak different languages and were therefore able to help patients for whom English was not their first language.
- We saw on a number of wards people who were deemed as vulnerable, with complex needs had extra staff looking after them. Patients were grouped within the same bay and received enhanced nursing care, sometimes on a one to one basis.
- To support patients with learning disabilities, staff consulted with the next of kin or carer in order to meet the needs of the patient and included them in handovers or ward rounds where possible. Staff explained their aim was to mimic the care the patient would receive in their home setting.

# Medical care (including older people's care)

- On Pitton ward, we saw an easy read, learning disability passport in use. This was a traffic light based document, which captures important information about the patient such as their likes and dislikes, health status, medication and captures the family or carers input.
- There was no specific learning disability team at the hospital but for planned care, policy stated staff liaised with the community team for people with learning disabilities or 'Key Worker' in the community to help with assessments and care planning. The Director of Nursing was the executive lead for services for patients with a learning disability.
- A senior directorate manager informed us that staff flagged patients with a learning disability whilst in AMU but no specific actions were taken. During daily safety briefings on wards, staff alerted colleagues to any patients with a learning disability so they could manage their care accordingly.
- The medical wards provided a suitable environment and a good level of care for patients living with dementia and received the Dementia Charter in 2013.
- Several medical wards at the hospital had undergone changes to make them dementia friendly. On Pitton ward, each bay was painted in a different pastel shade with the entrance-facing wall a darker shade so patients could easily distinguish between different areas. All bathroom doors were painted blue and had blue hand rails in the toilets or on toilet door frames so they were easy to distinguish. Flooring was non-slip and non-reflective and did not present a trip hazard to patients living with dementia. There were areas of different coloured ceiling lighting with changing colours to change the mood. There was good signage on doors at appropriate heights.
- The 'John's campaign' enabled carers of people living with dementia to stay with their relative round the clock and this permitted them to help care for the patient.
- Volunteers along with specialist staff ran a carers café twice per month. Carers with relatives or friends in hospital shared experiences and got support and advice from trained staff from the Alzheimer's society, Age UK and Care Support Wiltshire. A geriatric medicine consultant and psychiatric liaison nurse conducted a dementia specific ward round. The hospital had dementia champions on each ward.
- Staff reported that the use of the 'this is me' document worked well. This is a document which informs the carer as to how best to communicate with the patient, their care needs and personal preferences. The hospital had trained dementia champions and a consultant and a mental health liaison nurse ward round took place weekly.
- Staff served food using blue plates for patients living with dementia, the elderly or those patients at risk of malnutrition. The contrast in colour was particularly helpful because it made food look more appetising and has proven to increase food consumption during tests conducted on a number of wards within the hospital. Red trays were used to identify patients who needed extra help and support with eating.
- Staff offered relatives meals to encourage patients to eat socially.
- Food being served to patients looked appetising, and patients told us that food on the whole was of an acceptable standard and nutritious. Patients felt the finger food, which was often presented to patients with dexterity issues was well presented and there was a good variety and choice.
- We saw staff encouraged patients to eat and drink and offered help where needed. Patients told us staff encouraged them to drink in order to keep hydrated. The majority of patients we visited had a drink within their reach.
- Volunteers supported patients to eat and drink meals. Occupational therapy staff enabled patients to become increasingly independent with eating and drinking through mental and physical encouragement. Therapists also undertook assessments on some wards which had a kitchen installed where they assessed the patients' ability to cater for themselves and their readiness to cope at home.
- The hospital collected 'real time feedback' from patients. This was an initiative where staff spoke with patients and collected feedback about their experience of the hospital. It published monthly updates and discussed learning with its staff. Whilst there was a mixture of positive and negative comments, on average, food scored 9.8 out of 10.
- The 'engage programme' was a scheme staffed by volunteers to support the psychological wellbeing of older adults to alleviate distress and prevent depression and anxiety. It was available on all wards. Patients enjoyed singing, music, dance and storytelling to help keep their minds active. A programme called 'Elevate'

# Medical care (including older people's care)

delivered creative arts activities and workshops on the wards. These services were aimed at keeping patients' mood positive, and acted as a distraction to hospital life.

- As part of the Engage programme, we saw a 1950's style tea party on one ward. Volunteers dressed up and served tea to patients, and there were musicians present. The event took place at visiting time, which we were told is usual for such events. Patients clearly enjoyed the experience and we were informed the trust received positive feedback for this initiative.
- ArtCare provided art activities to patients where they could participate in different activities or view artwork displayed in the hospital. Two walking routes passed by a range of artwork around the hospital site. The indoor and outdoor routes were accessed by staff and patients. A representative from the service carried out one-to-one and group Artcare sessions weekly.
- Senior managers supported a social enterprise website which provided information to the families and friends of patients in hospital. Authorised staff and members could post updates to the site and messages could be sent and received between patients and carers.

## Learning from complaints and concerns

- Some patients we spoke with told us they knew how to make a complaint should they wish to do so. Information on how to make a complaint was found on wards, which included details about the process for making a complaint, how it would be handled and what would happen if they were not satisfied with the response. It informed the patient about their rights and was available in different languages and formats.
- A Customer Care Team was accessible to patients and visitors on level two of the hospital to deal with concerns and complaints.
- Staff were familiar with the complaints process. Staff knew how to escalate a patient or relatives concern but not all staff had experienced the need to raise a complaint.
- The majority of complaints within the medicine directorate related to communication and in particular to medical staff. As a result, the trust documented that it would share anonymised complaints with consultants to identify themes and learning.
- Displays outside of each ward within the medicine directorate highlighted patient complaints and

compliments. Wards displayed both negative comments, such as "the ward was noisy and chaotic", as well as positive ones, "Extremely well looked after". This showed an openness and transparency.

- The hospital reported a reduced number of complaints for July to September 2015 and time to resolve complaints in under 25 days significantly improved.
- The trust handled complaints effectively and confidentially and provided regular and timely updates for the complainant. The medical directorate arranged meetings with complainants as a first response to their complaint, particularly if it was complex or involved bereavement. The aim of this was to resolve the complaint in one attempt, rather than responding and then having the complaint reopened. On occasions, the 25 working day target was breached when trying to arrange a resolution meeting due to the availability of relevant staff members and the complainant. However, the complainant was kept informed of the timescales.
- The provider sometimes reopened some complaints if complainants felt their questions were not answered. Senior staff arranged face-to-face meetings with complainants to discuss their unresolved concerns where appropriate.
- Senior medical directorate management shared an example of how they dealt sensitively with a bereaved relative following the unavoidable death of a patient.

## Are medical care services well-led?

Good



We rated medical services as well led. The leadership, governance and culture promoted the delivery of high quality care. There was a clear set of values driven by quality and safety and staff were familiar with these.

There was a clear governance structure within the directorate. Governance, quality measurement and risk management featured regularly in a wide variety of meetings throughout the service.

The trust engaged its patients and visitors in regular feedback in order to improve the patients' experience in the hospital. Staff were committed to delivering a high quality of patient care.



# Medical care (including older people's care)

Staff were familiar with the hospital senior leadership team and told us senior leaders were approachable. Staff spoke highly of their managers and felt their views and concerns were listened to and acted upon. The staff survey showed staff recommended the hospital as a place to work.

## **Vision and strategy for this service**

- Staff we spoke with understood the trust's values of patient centred and safe care, professional, responsive and friendly. The values were developed with staff through consultation and focus groups in 2014, and were displayed around the hospital areas we visited.
- Senior staff did not communicate to us a clinical service strategy or vision for the future of the service, other than those plans linked to a single sex accommodation action plan, activities to improve patient flow and new models of patient care. The new models of care included changes to the elderly care model and the plans to relocate the acute medical unit to level 2 to provide a co-location with the rapid access care of the elderly ward Durrington. There was also a focus on improving the discharge process in collaboration with community providers. These were schemes that the trust reported would enable earlier discharge from the hospital and support improvements in patient flow.
- Workforce priorities included recruitment and development of the medicine service. Staff were aware of the recruitment strategy that was ongoing in the hospital and senior leaders communicated a policy for recruitment and retention which included further recruitment of overseas staff.

## **Governance, risk management and quality measurement**

- The trust had an effective governance framework which supported the delivery of good care. The trust held regular clinical governance half day meetings where part of the meeting was departmental governance and the other part was for the clinical specialities. Each speciality held monthly business meetings and clinical governance and quality was a standing agenda item. For example, the cardiology division governance group gave an overview of their services and covered a range of topics including updates and presentations, research, patient safety and mortality and morbidity. It conducted separate mortality and morbidity reviews at two monthly intervals.

- Governance within the medical directorate followed the structure outlined by the trust. All staff reported to the directorate management through ward and department leads. Medical directorate management met weekly and governance was a standing agenda item for all meetings. At this level, information was fed up to the trusts governance structure on a monthly basis. Staff could report directly to the directorate management team if they were not happy with the response they received from ward leads.
- There were arrangements in place for identifying, recording and managing risks, issues and actions to mitigate these. The medicine directorates risk register was reviewed regularly and high risks items which scored 12 or above were monitored through quarterly quality performance meetings. Monitoring of this was documented with the minutes and the trust risk register updated.
- The medical directorate conducted 'stocktake' meetings three monthly, which covered all specialities and actions were documented and reviewed.
- Lead clinicians within the medical directorate met every month except for August and December. This process was established to ensure clinicians across the specialities shared learning from their fields, in particular from mortality and morbidity reviews.
- The acute medical unit held monthly risk meetings that included input from a senior consultant, a senior sister and a representative from the risk management team.
- Senior leaders within the organisation visited wards as part of the 'executive led quality and safety walk rounds'. It grouped feedback to individual wards under the headings of safe, effective, caring, responsive and well led. This provided an overview of some of the key areas of concern or strength and progress against issues highlighted for improvement.
- Senior therapy staff felt information flowed up and down through the governance structure easily. Quarterly governance meetings changed to accommodate the hospital's spinal unit.
- Staff were relatively aware of the risks that were on the risk register at a divisional level and those risks identified on the ward were verified by the divisional risk registers.



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- Senior staff within the directorate articulated a clear plan to address the top risks within the directorate, and these were evident within the strategy and workforce priorities. On the whole, items on the risk register were aligned with what staff told us was on their worry list.
- Mixed sex accommodation breaches appeared on the medical services risk register, for which an action plan was attributed. However, non-clinical bed moves did not appear on the risk register, despite the acknowledgement by senior staff that this occurred. This issue was attributed to flow issues within the hospital in general due to the limited estate capacity. A plan to address limited estate capacity had been submitted at the time of the inspection and was awaiting a decision.
- There was a systematic programme of clinical audit, which was used to monitor quality. The audit programme looked at local and national audits for the medical division. Each audit had a named lead person, showed whether the trust was compliant with the hospital's policies, local and national guidelines, a date for completion and whether an action plan was signed off.

## Leadership of service

- The medicine directorate was divided into specialities and included the acute medical unit, the emergency department and palliative care, all of which were led by a directorate managers, clinical director and a senior nurse. Directorate leadership met with senior staff on the wards regularly to discuss care, safety and staffing.
- The directorate senior nurses visited each ward every morning Monday to Friday to discuss incidents, concerns, staffing discharge and flow. A senior band seven nurse performed this role at the weekend and provided a report to the directorate senior nurses, so they felt assured they had a good oversight of care on the wards at all times.
- We reviewed departmental and medical speciality meeting minutes and the senior directorate nurse informed us of a number of meetings that took place on a regular basis that ensured learning and information was shared effectively within the directorate. For example, senior band seven nurses met on a monthly basis with the senior directorate nursing team to discuss a wide range of quality and safety measures. This included, all safety incidents, dementia care, falls, infection control, and grade two or above pressure ulcer

cluster reviews with root cause analyses. The ward sister, supported by the directorate senior nurses conducted a root cause analysis for every fall resulting in fracture or significant harm. Together with a member of the risk management team, they presented the findings to the Chief Executive. This demonstrated a good flow of information and learning within the directorate, from board to ward.

- Staff told us the chief executive and the senior leadership team were visible in the hospital and they were offered a range of opportunities to speak with them to discuss ideas for improving the service or to raise any worries they had.
- Staff were able to raise concerns in line with the Trust's Whistleblowing Policy. This policy enabled staff to raise concerns about misconduct or wrongdoing at work in a way which protected their interests, and which ensured concerns were investigated properly.

## Culture within the service

- Staff within the hospital spoke highly of the culture within the organisation and felt respected and valued. Nursing staff on the acute medical unit felt there was a culture of openness where they were supported by staff of all seniority. One nurse commented that all consultants were approachable and interacted well with all levels of staff. Other staff concurred they would feel able to question or challenge all levels of seniority if they had a concern about that person or their actions.
- Trainee doctors told us they were attracted to the hospital as it had a reputation for being friendly and supportive. They felt encouraged by senior staff who were open and approachable, which enabled their learning. One trainee doctor told us that senior staff sought them out when they first arrived on the ward and always got involved if they had concerns or if issues arose.
- Many staff across a wide variety of roles and grades spoke of the familial culture within the hospital. Some staff had worked within the trust for many years and other said how they travelled past a hospital that was more local to them, in order to work at Salisbury hospital.
- Nurses recruited from overseas from a number of different countries could not speak highly enough about their experience in working for Salisbury hospital. They felt well supported to carry out their role and were able to request further training or remain as supernumerary

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following their induction programme, if they felt they needed more support. They told us that colleagues of all seniority were willing to help and support them with their learning for the role and with other concerns relating English being a second language for them.

- Staff spoke highly about their managers and we saw senior medical staff interact positively with therapists, nursing staff, nursing assistants and auxiliary staff.
- There was a culture which centred on the needs and experience of patients using the hospital and this was reflected in staff's behaviour and through the trusts values.

## Public engagement

- In the national inpatient survey, patients rated their care well and they felt that they were treated with respect and dignity. Areas of concern such as noise at night was well documented within the directorate's meeting minutes and action plans were in place to address this.
- There was a willingness within the trust to engage with patients and visitors demonstrated through the real time feedback initiative which was carried out on a monthly basis. The person conducting the interviews fed back to the wards immediately and followed this up with emails to the relevant areas and their managers. The trust analysed and distributed quantitative data to relevant areas the following month. This gave patients and their carers an opportunity to address any issues or concerns there and then, as well as the opportunity to discuss positive aspects of their experience within the hospital.

## Staff engagement

- We saw evidence of internal staff engagement via a staff survey and an action plan was in place to address issues arising from the staff survey. The top five ranking areas were: staff motivation at work, job satisfaction, support from immediate managers, recommending the trust as a place to work, and the percentage of staff reporting errors, near misses or incidents witnessed.
- The trust issued weekly newsletters and sent out an email broadcast to pass information and messages from the senior leadership team.
- Staff within the endoscopy unit ran an initiative called 'rate your room' where nurses and endoscopists rated their service, collated comments and published a







quarterly report based on their opinions of how the service ran on a daily basis. It included positive comments, areas for improvement and actions to be taken as a result. Comments related to the flow of the service, equipment issues, team working and both the positive or negative attitude of some staff which the team felt needed to be recognised and addressed.

- There was a good level of interaction between staff and the board and we heard a number of examples of how ward staff had interacted with the board to present ideas and proposals.
- Cardiologists had good access and input to the board, which they said worked very well. For example, the board accepted seven business cases in recent years and was considering two others. They felt proud of their service and that there was a good level of interaction between medical specialities.

## Innovation, improvement and sustainability

- Salisbury hospital were one of 22 trusts nationally who took part in the Lord Carter staffing acuity work. Senior leaders working on the project told us staff on wards will soon begin using hand held computers to input staffing data, patient acuity and dependency, and are piloting this on five wards. This project aimed to ensure staffing levels and skill mix were appropriate, safe and sustainable for the future.
- A number of developments within the medical services that will affect the bed base model were underway. Senior leadership informed us the plan to relocate the acute medical unit to level 2 in the hospital, on Farley and Nunton ward areas, would enable the expansion of the AMU footprint. The directorate submitted a capital bid in September 2015. They report this will "improve the efficiency of ambulatory care and maximise the effectiveness of Salisbury hospital's 'front door'". In combination with the ongoing 'referral to speciality model', it is predicted that this will enable the hospital to better manage the rising demand in non-elective pressure, both now and in the future.
- Therapy staff created a poster with rehabilitation objectives, which they presented at a quarterly governance meeting. Other areas of the hospital such as the stroke ward were considering a way of developing the tool to support stroke patients.

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

## Information about the service

Salisbury District Hospital provides a range of surgery and associated services and is the regional centre for specialist burns and plastic surgery. Within the hospital, the surgery teams were either part of the musculo-skeletal directorate, or the surgery directorate. These directorates included a number of services written about elsewhere in this report and some data, such as training for example, refers to the whole directorate.

The hospital had a main operating theatre unit with eight operating theatres and an 11-bed recovery area (inpatient surgery). There was a day-case surgery unit with six operating theatres, recovery areas, and two wards for patients to stay while they were assessed before going home. The Burns Centre also had a dedicated operating theatre and recovery area for burns and plastic surgery.

Surgery performed included urology, trauma and orthopaedic, spinal surgery, general surgery, breast, colorectal, vascular, ophthalmology, oral, Maxillofacial, ear, nose and throat, burns and plastic surgery. Surgery was provided as both elective (planned) and in an emergency. The hospital also carried out interventional radiology: a process of using minimally invasive image-guided procedures to diagnose and treat diseases.

The hospital had six surgery wards. Amesbury Suite, a 32-bed ward for patients predominantly having planned or elective orthopaedic or trauma surgery; Britford ward, a 23-bed ward for patients having general surgery; Chilmark Suite, a 24-bed ward for patients having trauma or orthopaedic surgery; Downton ward, a 27-bed ward for

short stay patients undergoing general surgery. Laverstock ward was the 26-bed ward for patients having specialist plastic surgery and the Burns Centre was the 17-bed specialist burns unit. Clarendon was the trust's four-bed surgical unit for privately-funded patients.

Surgery services also ran a weekday pre-operative assessment unit; a surgical admissions lounge within the operating theatre suite; and a seven-day surgical assessment unit currently located temporarily within Wilton ward while the usual unit on Britford ward was being updated and refurbished. This was used for patients coming through the emergency department or admitted via their GP to be assessed for potential surgery. Other services included a hospital sterilisation and decontamination service.

On this inspection we visited the surgery services on Wednesday 2, Thursday 3 and Friday 4 December 2015 and made an unannounced visit for the day on Sunday 13 October 2015. We met with patients and their relatives and friends. We visited all the surgery wards, the regional burns and plastic surgery centres, main theatres including the recovery area, the pre-operative assessment department, surgical admission lounge, the day surgery unit, surgical assessment unit, and hospital sterilisation and decontamination services. We spoke with staff, including nurses, practitioners, and nursing assistants, the main theatres and day-case unit managers, and the recovery team. We met the senior management teams for the surgery and musculo-skeletal directorates, senior ward

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staff, consultants, senior doctors, and junior doctors. We also talked with pharmacy staff, housekeeping staff, and physiotherapists. We observed care and looked at records and data.

Salisbury District Hospital carried out around 23,000 operations in 2014. Of these, 52% were carried out as day-case procedures, 21% as inpatient elective (planned) cases, and 27% as inpatient emergency cases.

## Summary of findings

We have judged surgery services overall as requiring improvement.

As the hospital recognised, nursing and operating-department practitioner staffing levels were not always at established or recommended levels safe. In some wards the established levels of nursing care provided at night were not following recommended guidance and unsafe. There were shifts not fully covered by nursing and healthcare staff on all wards, despite high use of agency staff. Patients praised the care but a number felt reluctant to call for support due to a perception of nurses and nursing assistants being too busy.

Safety in operating theatres was good but some improvements were needed in assurance and culture. Problems with surgical instrument sets needed resolution. Reviews of deaths in the hospital needed to be improved to show learning and improvement happened. Security of patient charts needed to be improved as some were not being kept confidential. Staff mandatory training updates was not meeting trust targets.

The hospital was clean and infection prevention and control protocols followed. Incidents and near misses were being well reported and investigated. There was a safe level of cover from the medical staff and deteriorating patients were recognised and responded to.

Length of stay in the hospital was mostly better than the England average. Patients' pain, nutrition and hydration were well managed with specialist input when needed. Staff were skilled and experienced, although not all had received an annual performance review. There was strong multidisciplinary input to patient care. Important services were provided seven days a week and there was good access to information. The majority of audits showed patients were getting good outcomes, but some audit results needed more attention where they were not being used to demonstrate change, learning or improvement.

Feedback from patients and their families had been almost entirely positive overall and several patients

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described their care to us as excellent. The Friends and Family Test produced excellent results. Patients we met in the wards and other units spoke highly of the kindness and caring of all staff, although not without mentioning how busy staff were. Staff ensured patients experienced compassionate care, and worked hard to promote their dignity and human rights.

The hospital had not resolved the conflict between meeting targets for patients to have treatment and putting undue pressure on services to perform. There were many aspects of good responsiveness, but pressure for beds was leading to too many patients being inappropriately discharged from the main theatres or day-surgery unit. As with most NHS hospitals, this hospital was regularly faced with a high number of patients who were fit for discharge, but without transfer of care packages.

Patients were complimentary about the food. There was a wide-range of leaflets and information for patients and people with additional needs were being looked after. Cancelled operations were low, and the pre-admission, admission and discharge services provided good support.

The surgery service had an effective governance process, although some areas needed to be improved to show a consistent approach. There was good leadership and local-level support for staff. All the staff we met showed commitment to their patients, their responsibilities and one another. There was a strong camaraderie within teams. We were impressed with the loyalty and attitude of the staff we met, although some were stressed and anxious, and this did not always appear to have been recognised. Staff were recognised through awards made by the trust for their commitment, professionalism and going the extra mile for the patient.

## Are surgery services safe?

Requires improvement



We have judged the safety of surgery services as requiring improvement. The nursing and operating-department practitioner staffing levels in some of the wards and operating theatres were not sufficient to provide safe care at all times. There was a relatively high use of bank and agency staff to fill vacant shifts and although not all shifts were filled, the position had improved over the last six months.

The audit of the World Health Organisation surgical safety checklist had in the recent past been inadequate. This had recently been recognised with a new audit and observation protocol. As yet there were no results to review to determine if the checklist was being used safely as it was early days with the new regime. There was, however, no evidence from our observations of the safety checks in theatres not being performed effectively. Policies and procedures for use of the checklist had not been developed.

There were continuing and as yet unresolved problems with damage to the drapes wrapping sterilised surgical instrument sets. Measures put in place had yet to find a satisfactory solution. The review of hospital deaths was being carried out, but there was no evidence from reports of any actions to improve patients care or learning being shared. There was no systematic review of high-risk deaths. There was a lack of security with some patient charts, including medicine charts, which were left unsupervised outside of patient rooms. In terms of training, staff were not meeting trust targets for updating their knowledge in mandatory subjects and safeguarding.

Otherwise, incidents and near misses were being reported, investigated and actions and learning shared with and fed back to staff. Avoidable patient harm was relatively low with equipment readily available and used to prevent avoidable harm. The surgery wards, operating theatres and equipment were clean and well maintained. Staff adhered to infection prevention and control principles and guidelines. Medicines were well managed and patient records were well completed and practical. The surgery teams assessed and responded well to deteriorating patients.



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There was safe cover from the medical teams. There was a committed team of consultants, junior and trainee doctors who put patients at the centre of their work.

## Incidents

- The surgery services acted upon significant incidents. The hospital had reported one Never Event in adult surgery services in the last 12 months (February 2015). This event related to a retained swab following an operation and resulted in the patient needing to undergo further surgery after developing subsequent problems. The safety procedures in the operating theatre did indicate there was a missing swab at the end of the operation, but, despite some extensive review by the surgical team, it was not located. Consequently, the root-cause analysis report into the event contained clear details of the procedure and examined and investigated where failings had occurred. A number of areas for change and improvement were identified. An action plan was produced with staff made accountable for the changes to be made.

One area of the investigation did not have sufficient profile in the root-cause analysis action plan. This related to staff treating the patient in the two weeks following the operation not being aware of the potential for the retained swab. The patient's notes did not make this clear enough.

- All staff we met were open and honest about reporting incidents. Staff we spoke with in theatre, surgery units and wards said there were no barriers to reporting incidents. We were told how the recent implementation of an electronic system had made this easier. Access to the system was on the front page of the trust intranet. Staff said they were encouraged and reminded to report incidents by senior staff. Incidents were investigated when this was required, actions identified, and most staff said they received feedback. The statistics for each ward and unit showed a fairly regular number of incidents reported each month. The highest number of incidents (often indicative of a good culture of reporting) was within main theatres. Many of these were related to problems with damage to wrapping on sterilised surgical trays. The trust, overall, was above the NHS England average for reporting incidents. Again, this could be taken as an indicator of a strong reporting culture by staff.

- Staff were aware of the need and importance of reporting and acting upon near misses. There had been two notable near miss incidents in the main operating theatres and one in the day-surgery unit which were avoided by good use of the surgical safety checklist and the diligence of the staff team. These were recognised, reported, investigated, and learning was shared across the service.
- There had been eight serious incidents in surgery services in the 12 months from August 2014 to July 2015. Four of these had been surgery-related, discussed above, two were serious hospital-acquired pressure ulcers, one was a patient fall, and the other described as a 'adverse media coverage or public concern.'
- Patient mortality and morbidity (M&M) was reviewed by the surgical teams and hospital-wide. There were actions and learning identified within the hospital-wide mortality working group, but with insufficient evidence at speciality level to show how agreed actions were being delivered, reviewed, and led to improvements. Also, patient deaths were not categorised within six classifications which ranged from 'no evidence for avoidability' to 'definitely avoidable'. under the National Confidential Enquiry into Patient Outcome and Death five classifications, but were classified by a similar system. This would provide staff with data to determine how many deaths had taken place within nationally recognised categorisations. The M&M meeting minutes did not demonstrate if or how staff were accountable for actions agreed from reviews or demonstrate improvements from actions taken. We reviewed sets of minutes provided for the general surgery team and a set from part of the musculo-skeletal division (it was not clear which part and there was no indication of who attended). There was also a mortality working group held every two months. The minutes from this group had more structure, although the role of the staff who attended was not shown. There were also a number of staff who did not attend any of the three meetings between March and July 2015. The meetings showed there were actions attributed to staff and, but no evidence to show if these had been completed. The actions and learning were distributed to clinicians within the trust. In the minutes we reviewed, there were no investigations into groups of deaths and no evidence of a complete review of all high-risk deaths. Some of these gaps had been



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partially recognised at the working group meeting, but without any actions being agreed. The speciality M&M meeting minutes did not demonstrate if or how staff were accountable for actions agreed from reviews or demonstrate improvements from actions taken. We reviewed sets of minutes provided for the general surgery team and a set from part of the musculo-skeletal division (it was not clear which part and there was no indication of who attended).

- Duty of Candour had been introduced to staff, although it was not referred to in the serious incident report we reviewed. Those staff talked with were aware of the new regulation to be open, transparent and candid with patients and relatives when things went wrong, and apologise to them. From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to incidents or harm categorised as 'notifiable safety incidents'. The incident referred to above, where a patient suffered from a retained swab after an operation, did not mention whether the Duty of Candour had been applied in this case. It referred to a conversation with the patient and the family, but not how this had been conducted.

## World Health Organisation Surgical Safety Checklist

- The hospital used the internationally recognised World Health Organisation surgical safety checklist ('the checklist') in all surgical procedures, although had work to do to embed the practice more consistently and professionally. The checklist was a procedure carried out to review all safety elements of the patient's operation including, for example, it was the correct patient, the correct operating site, all instruments and swabs had been accounted for, and all the staff were clear in their roles and responsibilities. Following the introduction of the National Patient Safety Agency 'Five Steps to Safer Surgery 2010' guidance, practice was extended in operating theatres to include a briefing at the beginning of a surgical list and a debriefing before members of the team left the theatre or department. Senior staff in directorate management team and those running the theatres were open and honest in disclosing to us there were some cultural issues with some members of the surgery team. This had led to a difference in quality and compliance with the way the

list was used. As a result there was a recent relaunch of the checklist and requirement for professionalism, openness, and challenge from theatre teams. There was, however, no policy guiding staff to how the checklist was to be used and best practice to be followed. It was not referred to in the theatre operational policy.

- Although we heard of some issues with culture and consistency with the checklist, we observed good practice in the operating theatres, both main and day-surgery. Staff adhered to those parts of the checklist protocol we observed. All staff involved were present and included in working through the checklist as required. There were no distractions. We observed practice and felt it appeared 'natural' (not being performed for our benefit). The trust was now anaesthetising almost all patients in the operating theatre rather than in the preceding anaesthetic room. This was improving teamwork and the culture among teams (often known as 'human factors').
- The service had recently recognised the previous audit work for the determining compliance with the checklist was not providing any assurance, and the whole procedure had just been relaunched. In the previous procedure, the checklist was completed electronically. Compliance with the requirements of the checklist was being audited by checking there was a tick in the relevant box on the computer system. It had been recognised this did not show if staff were, as required, included in the reading and approval of the elements of the checklist and indicate any quality measurements. The audit did not demonstrate due process being followed and, it was agreed by senior staff, provided insufficient assurance. The paper checklist had therefore been reintroduced to provide a more inclusive and quality process. A system to audit future performance with compliance had been developed which included observation. There were, as yet, no results to review as the newly relaunched audit programme had yet to be conducted within a meaningful time frame. The new system had yet to be extended to production of a checklist compliance policy. Links had now been made with another NHS trust known for expertise in peri-operative safety to review practices and procedures in Salisbury operating theatres.

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## Safety thermometer

- Data on avoidable patient harm data was collected and reported for all surgical areas using the Safety Thermometer and was relatively similar to other acute hospitals when compared nationally. As required, the hospital reported data on avoidable patient harm to the NHS Health and Social Care Information Centre each month. This data provided a snapshot of avoidable patient harms occurring on one specific day each month and could be measured against other hospitals and wards in the NHS. Data included hospital-acquired (new) pressure ulcers (the three more serious categories: two, three and four) and patient falls resulting in harm. The report also included incidences of catheter and urinary tract infections and venous thromboembolism. Within this snapshot view, the hospital overall had shown an improvement within the delivery of harm-free care in the 12 months from August 2014 to July 2015. It had improved from 88.2% in August 2014 to 94.16% in July 2015. By July 2015, the result had improved to meet the NHS average level of acute hospitals. There was an average overall of 91% of harm-free care delivered for 4,795 patients in these 12 months. This showed the hospital was slightly below (that is worse than) the average for NHS acute hospitals of 93.9% for the same period.
- At surgical ward level there was a varied but not poor performance. Amesbury Suite, the Burns Centre, and Laverstock ward had the best overall performance in the snapshot view. They all had six out of 12 months with 100% harm-free care. Otherwise in surgery wards, there had been only infrequent months where harm-free had fallen below 90%.
- In terms of harm, falls causing harm were low throughout the surgical wards. There had been just four reported across the surgical wards in the snapshot of data for the 12 months. There had been three category two 'new' pressure ulcers and four category three 'new' pressure ulcers. New pressure ulcers are those acquired within 72 hours of the patient's admission to hospital, three of which were the second highest grade (category three) and two the highest category (category four). The avoidable harm with the highest occurrence was 16 catheter and urinary tract infections – with six of these occurring on Chilmark Suite and seven on Downton ward.
- There was senior nurse review of pressure ulcer management. Nursing audits looked at pressure ulcer prevention and a report was produced each year. In the latest report from May 2015, the audit report looked at 90 patient records in relation to pressure ulcer care. The trust was using the Braden Scale as the tool for assessing pressure ulcers. This assessed patients for different things including the patient's sensory perception, activity levels, mobility and other medical areas. The majority of the assessments were working well but the accuracy of the assessment measured against the Braden Scale left room for improvement. Thirty of the 90 records did not give an accurate assessment of the injury. Otherwise, the most appropriate equipment had been used for all the 90 patients checked. The SKIN bundle (a care plan to recognise Surface, Keep moving, Incontinence and Nutrition) was looked at within the 35 records where these had been required, and 30 of these were completed well – which met the trust target. On Chilmark ward, staff had recognised pressure ulcers could develop below plaster casts. A review of an incident had led to the creation and use of a plaster-cast skin check tool.
- There was senior nurse review of falls risk assessments and prevention. The audit report from May 2015 looked at 85 records for quality of the assessment on admission of the patient for risk of falls. Of these, all but one had been completed appropriately. Of 39 records looked at to see if the reassessment of the patient was carried out, 80% were completed. There was therefore some room to improve in this area. Records for 90 patients were looked at for appropriate completion of bed-rail assessments and 86 of these were acceptable. In practice, staff were proactive in helping patients avoid falls. On Downton ward, for example, anti-slip footwear was provided to patients after an analysis of the cause of a small number of falls leading to fractures. Patients who were at risk from falls were reminded to use their call bells and wait for someone to support them.
- There was good use of equipment to help patients at risk from avoidable harm. This included the use of pressure relieving mattresses. Staff and patients said these were readily available when needed and care plans would indicate when they should be used. There were bed rails which could be used when patients were assessed as being at risk to falls. Patients were carefully

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assessed before these were used to ensure they were not just a form of restraint. Patients were provided with anti-embolism stockings when they were assessed as at risk to a blood clot (venous thromboembolism).

## Cleanliness, infection control and hygiene

- The inpatient ward areas of the hospital were visibly clean, tidy and well maintained. This included patient bed spaces, corridors, staff areas and equipment used both regularly and occasionally. Patient bed spaces were visibly clean in both the easy and hard to reach areas such as beneath beds and on top of high equipment. Bed linen was in good condition, visibly clean and free from stains or damage to the material. Storage cupboards were well organised with most equipment on shelving units to prevent dust and dirt gathering around and beneath objects. Several patients we met on the wards said the cleaners were regularly seen. They regularly dusted at height (such as curtain rails), cleaning floors, bathrooms, and under beds.
- The main and day-surgery operating theatre units we visited were visibly clean, well-organised and maintained. The recovery areas in both units could be effectively cleaned at the start of the day, as they were empty of beds or trolleys. The manager of the main theatres commented upon how they valued their experienced and trusted cleaner. Members of staff knew who was responsible for the various cleaning roles. This ensured complex machines, equipment and areas were maintained and cleaned by trained personnel.
- The surgery services had an exemplary result for levels of hospital-acquired infection. There were zero levels of methicillin resistant *Staphylococcus aureus* (MRSA) and methicillin-susceptible *Staphylococcus aureus* (MSSA) in the six months from April to October 2015. There had been just two incidences of hospital-acquired *Clostridium difficile*, one in May and one in August 2015.
- There were reasonable investigations into any incidence of hospital-acquired infection, but some sections of reviews we saw were not fully completed. We looked at incident investigations for the two most recent incidences of *Clostridium difficile*. The basis for the reviews was good. It focused upon which areas of the hospital/ward had been visited by the patient, any pressures on staff, what equipment had been used, and the results for cleaning and hand hygiene around the time of the incident. In the report for Britford ward in April 2015, the section on whether the patient was isolated and equipment was designated for single use was not completed. There were some shortcomings identified in the Burns unit when the investigation into the *Clostridium difficile* incident was undertaken in August 2015. There were, however, no actions to require staff to re-audit the wards and areas of the investigation once the shortcomings had been addressed.
- All staff we met and/or observed followed infection prevention and control protocols. Nurses, allied health professionals (physiotherapists and occupational therapists) and nursing assistants wore clean and well-maintained uniforms. They were adhering to the rules around minimal jewellery, short and clean nails, and being bare below the elbow. Medical staff and staff not required to be in uniform (such as pharmacists) adhered to trust policy in the same way. All the staff we observed washed their hands and used hand gel as required. Visitors were encouraged to do the same. We saw staff wearing personal protective equipment (aprons and gloves) when required. There was sufficient stock of personal protective equipment and hand-wash sinks, soap, paper towels and hand gel in clearly visible areas. Patients commented how they had observed staff washing their hands “all the time” and “they don’t go anywhere without washing their hands. I’ve been most impressed.”
- There was a protocol for staff to follow to treat and manage a patient with diarrhoea or recognised or suspected *Clostridium difficile*. This raised the level of infection prevention and control for the patient, staff, visitors and the environment. One area of a higher level of practice was around hand-washing. The hospital had recognised the use of alcohol hand gels had limited effectiveness against *Clostridium difficile* and was not recommended for patients with diarrhoea. All those coming into contact with the patient were therefore required to wash their hands with soap and water before and after every contact with the patient or the environment.
- There were variable results from hand-hygiene audits. Although the majority of nursing audits scored 100%, there were some failures in observed hand-washing protocols among the medical staff. We were provided with data of observation audits from April to July 2015.

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In forty sets of data for surgical units/wards, main theatres and recovery, the day-surgery unit, pre-operative assessment there were only three out of 39 measures (one set of data was missing) where the nurses did not score 100%. The sample size of around eight nurses assessed on each observation was a good ratio. It was noted as good practice there was a larger sample in May 2015 in Laverstock ward (20 nurses sampled) as this ward had an incidence of *Clostridium difficile* in that month. This was one of the results which did not return 100% compliance (90%). It was noted the audit for Laverstock ward for June 2015 was then not done or provided to the infection prevention and control team. In July 2015, however, Laverstock nurses' compliance was 100%. Compliance for nurses on Amesbury Suite, Chilmark Suite, Britford ward, Downton ward, main theatres and recovery, the surgical assessment lounge and pre-operative unit was 100% throughout this period.

For medical staff there were 16 occasions out of the 39 measures (one set of data was missing) where medical staff fell below 100%. Improvements were made, however, over the time period. In the surgery wards of the musculo-skeletal division, seven out of 12 of the audits in April to June 2015 were below 100%. By July 2015, however, all medical staff scored 100%. There was a 100% performance over the four months for medical staff in the surgical assessment unit, but Britford ward medical staff had not scored 100% since April 2015. Allied health professionals, so physiotherapists, occupational therapists and dieticians, for example, scored mostly 100%.

- Patients recognised good cleaning, and results from surveys showed improvement. The trust had scored well in cleanliness in the Patient-Led Assessment of the Care Environment (PLACE) surveys in 2013, 2014 and 2015. In 2015 the trust improved to score 99/100 (up from 87 in 2013) which was the just above (better than) the NHS England average of 98.
- Clinical waste was well managed. Single-use items of equipment were disposed of appropriately, either in clinical waste bins or sharp-instrument containers. None of the waste bins or containers we saw on the wards or within the theatre units were unacceptably full. Nursing staff said they were emptied or removed and replaced regularly.

## Environment and equipment

- Most arrangements for the delivery and removal of reusable sterile surgical instruments were appropriate, but there was an area where they were not always safely removed in the day-surgery unit. In the day-surgery unit, clean instruments were stored outside of the sluice areas. Used instruments, which were re-wrapped in their original packaging, were taken past these clean instruments on an open trolley, before being deposited in a closed trolley for transport to sterile services. Although there was minimal risk of cross-contamination, staff admitted they had not recognised or addressed its potential. In main theatres, sterile instruments were stored on shelves in their sets and wrapped in surgical fabric drapes. Any used instruments were removed in an area at the rear of the operating theatres designated as a 'dirty' corridor. Used instruments were taken through the rear of the sluice area and deposited into a closed trolley for collection and processing by the decontamination and sterile services unit. There were storage problems with main theatre, in that there was little available space. However, there were surgical stocks in the 'dirty' corridor which should have been elsewhere. This included breast implants. Although there was minimal risk as they were sealed and in locked cupboards, this was the wrong environment for them to be stored.
- There were recognised, but nevertheless, slow to resolve problems with damage to the wrapping of sterile surgical instruments. Any sets of instruments could not be used if the wrapping they came with was damaged. This resulted in some operations being cancelled or rescheduled at very short notice if there was no other set available. The issue in main theatres had been improved to an extent by changing the storage racking, but the storage shelves were high, so this did not always solve the risk for sets stored at height. The wrapping could still be damaged when they were taken down from a high shelf. Day-surgery staff said they also had at least one set each day with packaging damaged. There had been some discussion about improving this in main theatres with marks being added to shelves to alert staff to not place heavy sets above these marks and on the high shelves. This had, however, not yet been properly implemented. The trust was trialling stainless steel boxes for surgical sets, but these were very expensive. A



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different type of more resilient wrap was also being trialled. The issues had been placed on the trust risk register although there did not appear to be a clear resolution.

- There was safe provision of resuscitation equipment, although a lack of clarity around the checking of one difficult-airway trolley in main theatres. Resuscitation trolleys and equipment including defibrillators on each ward and in the units were checked daily, with records showing completion on the vast majority of days in the last three months. The trolleys were a standard recognisable type, constructed from metal and red in colour. They were well placed within wards and units so they stood out and were easily accessible. Trolleys were locked with a breakable seal and, of those we checked, this number was recorded as part of the checking routine. This demonstrated the trolley had not been opened or equipment used or tampered with since it was last used. When we looked, the difficult-airway trolley in main theatre did not have a checklist to show it had been monitored and this could not be easily located when it was required.
- There was no resuscitation trolley in the upstairs area in the day-surgery unit. There was one located downstairs and this would be relocated to the upstairs area when this was used to admit patients overnight (which was a frequent occurrence). The requirement to locate the trolley was part of the protocol for staff to follow (and sign) when the day-surgery was opened for inpatients. We were impressed to see oxygen and suction equipment had been fitted into the patient lift between the two floors in the day-surgery unit. This improved patient safety in the event the lift failed when it was being used to move a patient.
- Surgery areas were mostly supplied and fitted with appropriate emergency equipment. Each bed space had emergency call buttons clearly marked. Recovery areas and ward beds had oxygen and suction at each bed space. There was, however, no piped oxygen or suction within the ward areas of the day-surgery unit. This would be acceptable if these wards were used as designed only for low-risk day-case surgery patients, but the unit was being used regularly for inpatients and also for more complex patients. There was portable oxygen available, and patients admitted to these wards overnight were assessed for their risks of needing a higher level of care. We were told that any patients who were likely to need oxygen and suction would not be admitted to the day-surgery unit for an overnight stay. This was backed-up by the patient admitting protocol, and staff said there had been no incidents reported from unsafe patient care of the availability of equipment.
- Almost all medical equipment in theatres had been serviced and maintained as required. We reviewed the servicing dates for equipment as at the end of September 2015 including things like scopes, operating tables, anaesthetic machines, ventilators and scanners. The exception to this comprehensive list was a number of items, mainly different scopes in the day surgery unit, which were due for servicing in early September, and two flowmeters due in August 2015 which had not been recorded by the end of September as now being compliant.
- In the areas we checked, all consumables and equipment were within their expiry date. The staff we met said the stocks, stores and trolleys were regularly checked by one of the nursing or healthcare team, or the theatre stock team in the operating theatres. Staff checked for evidence of damage to packaging or consumable stock (damaged items were then disposed of) and for items approaching or past their expiry date. We saw consumables and equipment in the departments were kept to a minimum of those things used often in order to reduce waste and the risk of expired equipment.
- Equipment was stored safely. Flammable products were in locked steel cabinets. Products deemed as hazardous to health were in locked cupboards and often in sluice or clinical rooms which were also locked and only accessible to approved staff.
- Almost all areas of the hospital we visited were secure. Staff had close-proximity cards to give them access to areas not open to the public. Some wards were secure at the front door and visitors were required to announce themselves before entering the area. People coming to the operating theatres who should not have direct access were met by a receptionist who, as they did with us, checked people's identity and asked them to wait to be escorted any further into the unit. Some of the wards were designed without doors at the entrance. Patients were, however in side rooms or bays and visitors had to

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walk past staff offices and nurses' stations which were often occupied. Security in these areas was, however, not ideal and this led to our concerns around the security of patient charts (see 'Records').

## Medicines

- Almost all medicines were supplied and stored securely on the wards, theatres and departments. Medicines, including liquids, were in locked cupboards with appropriate staff being responsible for the keys. There was one trolley in a locked room, but the trolley itself was not locked as required. There were arrangements for the supply of regular medicines. An inpatient pharmacy service supplied stock medicines to all wards and departments and dispensed discharge medicines for patients to take home. There was an emergency medicine stock which all staff we asked knew about and how to access it out of hours. Medicines' refrigerators were available with temperatures recorded daily to show medicines requiring refrigeration had been stored at a safe temperature. There were some liquid medicines without a date recorded on which they were opened, which was not in line with medicine practice and hospital policy.
- The ordering, receipt, storage, administration and disposal of controlled drugs were in accordance with the Misuse of Drugs Act 1971 and its associated regulations. We checked a number of stocks and the registers and found them to be accurate. There were manageable levels of stocks to prevent medicines going out of date and the risk of errors.
- In the patient records we reviewed there was consistent recording of patient allergies. We saw patient allergies (such as allergy to penicillin) transcribed to prescription charts and patients were wearing wristbands to indicate they had an allergy or intolerance.
- There was a regular audit for the use of antibiotics. This was work undertaken to improve the management of antibiotics by checking the duration of their use with patients, the route of administration and how they were being used. One ward was audited each fortnight and all patients receiving antibiotics were included in the audit. The most significant shortcoming determined by the audit was with wards documenting a date for when the antibiotic should be stopped or a review date. In audits since October 2014 to September 2015, there were 15

occasions where the surgery wards were not meeting an acceptable score of above 80% of records showing this date. This was from 26 audits, so more than half were not achieving 80%. There was no action plan presented with the report and we could not see this discussed through clinical governance in those minutes we reviewed.

## Records

- Records we reviewed were well completed, legible, timed and dated. We looked at 20 sets of nursing notes and 10 of medical notes. All those we saw were completed well. Notes made by all those involved with the patient's care were clear, contemporaneous and attributable to the member of staff writing them. The name and grade of the doctor reviewing the patient, the patient being seen within 12 hours of admission, the management plan for the patient, and ward round decisions, were documented in the notes. There was also good recording of input from the multi-disciplinary team; assessment of pressure ulcer, falls, and nutritional risks; and all the consent forms we saw were complete and appropriately signed.
- On a number of the wards there was some inattention to patient record safety and confidentiality. Some patient charts were stored in pockets on a rail outside of the patients' room. This included nursing charts and prescription charts. On some wards, as is trust practice, they were covered with a notice stating they were 'confidential' but not all. Staff said these records were only stored in this way if a patient was being barrier-nursed due to an infection. However, this was not the case as many patients were not being barrier-nursed but had their charts stored in this way. This left the charts open to be read, removed or potentially changed. The staff we asked admitted they had not considered situations where a patient's prescription chart should be kept highly confidential. They had not considered what confidential information could be revealed about a patient's health from, for example, prescription charts.
- Other patient notes and records were held securely in staff-only locked or lockable office, with the exception of notes in the surgical pre-operative assessment office. This lack of security would exist when the unit was open



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and the office unstaffed, as otherwise the whole unit would be locked. The senior sister on the unit said this had been raised with the estates' division, but the lock had yet to be fitted.

- There was a monthly audit of patient records to check for their completeness. There were nine different measures including if the patient had an observation chart, and all the right areas were completed and scored accurately. In the data we were provided with for January to June 2015, the surgery wards and units scored highly. There were just 13 occasions from 252 where the wards were not at 100% for these audits. In the January to March 2015 quarter there had been nine occasions which had reduced to four in the April to June 2015 quarter.

## Safeguarding

- Not all medical staff were up-to-date with their training to recognise and respond in order to safeguard a vulnerable person. The training compliance with safeguarding vulnerable adults and safeguarding children (level 2) as at September 2015 showed 70% of medical and dental staff were compliant with the training. The trust target was 85%. Nursing staff did, however, meet targets in adult safeguarding refresher training and were just below for the child safeguarding course. There were 91% of the nursing staff up to date with the safeguarding adults training and 83% with the safeguarding children update.
- There were policies, systems and processes for reporting and recording abuse. The safeguarding adults' at risk policy had been implemented in accordance with national guidelines and was due for review in June 2017. The policy did not yet mention, however, the Care Act (2014) which had superseded the government's 'No Secrets' paper of 2000. The policy did, however, reference the local authorities' policies to ensure approved and recognised local safeguarding systems and processes were adhered to. The policy listed definitions and types of abuse and who might be at risk and from whom. It was linked with the provisions of the Mental Capacity Act (2005) in relation to deciding if a person was vulnerable due to their lack of mental capacity to make their own decisions. The policies (including the policy for child safeguarding which was due for review in November 2015) clearly described the responsibilities for staff in reporting concerns for both

adults and children, whom, as required, were subject to different procedures. There were checklists and flowcharts for staff to follow to ensure relevant information was captured and the appropriate people informed.

- Staff we spoke with were clear about reporting safeguarding, allegations or suspicions of abuse. They understood their responsibilities and the trust's processes for reporting any suspected abuse. Staff said they would report concerns about a patient, but also concerns for someone who was either accompanying a patient or might be affected by the patient (such as a child or carer in the family home).

## Mandatory training

- Mandatory update training was not meeting trust targets. Staff were trained at induction and then updated in a wide range of statutory and mandatory subjects at various intervals. The staff (in the musculo-skeletal and surgery directorates) were not meeting trust target levels overall for 85% having updated their training. The training included a wide range of topics such as mental capacity, infection control, and health and safety topics. Compliance with the mandatory training requirements at the end of September 2015, against the trust target of 85%, showed medical and dental staff at 64% and nursing staff at 78%.
- In terms of subject matter, there was good compliance with update training in health and safety, equality and diversity, and, infection prevention and control among the nursing staff. There was poor performance from the medical staff in updating training in mental capacity and infection prevention and control. The nurses and medical staff were poor in updating their information governance training, fire safety and safeguarding children (level 1 and 2).

## Assessing and responding to patient risk

- Surgical patients admitted to the day-surgery unit for overnight care were assessed for their suitability to minimise the risks of staying in a unit not designed for overnight stays. There was a protocol used for any patients being suggested for admission to the unit. The criteria included patients being clinically stable; having no complex mental health needs (such as living with dementia); and being independently mobile.

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- The hospital had a policy for monitoring acutely ill patients which was being audited for effectiveness. The hospital had implemented and was using the Modified Early Warning Score system for the monitoring of adult patients on wards. The hospital policy recognised best practice in this system as promoted by the National Confidential Enquiry into Patient Outcome and Death and the National Institute for Health and Care Excellence (NICE) guidance on care of the acutely unwell patient in hospital (NICE 50). Hospital staff used a system of raising alerts through numerical scoring of patient observations. The system was used on wards and also in recovery areas. In patient records we saw the early warning score charts completed and in use appropriately. The hospital carried out a quarterly audit of the charts, reviewing five on each ward. In the data provided for April to June 2015, the hospital scored 96% for completion and accuracy of the charts. The best result was for observation charts being used (100%) but there were less good results in this quarter for the escalation of patient care being documented. This was only done in 71% of records in the period audited.
- The hospital had an outreach team (the critical care outreach team) to respond to deteriorating patients and emergencies around the clock. The outreach team was staffed by trained critical care nurses, and provided cover 24 hours a day, as recommended by the Faculty of Intensive Care Medicine Core Standards.
- Patients were assessed pre-operatively for any risks to or from their proposed surgery. The nurse-led team in the pre-operative assessment unit assessed both day-surgery and main-surgery patients. Patients were assessed for their general health and any medicine or other potential complications to be considered before surgery could take place. Anaesthetists also provided patient assessment and consultation through the pre-operative clinics each Friday morning.

## Nursing staffing

- A number of patients we met were concerned about nursing-staff levels. We heard numerous concerns about staff being “rushed off their feet” and “just doing too much.” We also heard how staff were very caring for patients, but not enough about themselves. One patient remarked on one member of staff feeling faint as they had not found time to take their break. They left the bay

for five minutes to get something to eat. Another patient said they had heard a nurse crying as they felt unable to give a patient as much time as they needed. Other comments included:

- A patient waiting for 30 minutes on a bed pan as no one came back to take it away.
- A patient was having their bed changed at 9:30am. The member of staff was called away and eventually the bed was changed at 5pm when the patient felt they could not sit in their chair any longer so reminded staff. They said staff were apologetic, but had too much to do.
- Several patients told us they felt they could not use their call bells as either there were patients who needed the nurses more than they did, or they felt they were being unhelpful.
- A number of patients commented how they felt they had to wait a long time at night to see a member of staff. We were told by three patients in side rooms how this could be unsettling as they were in a closed room and were never quite sure if they had been heard. They said staff always apologised for how long it might take them to come, but patients said staff sometimes appeared even more rushed off their feet at night.
- Staff on the day surgery unit told us they felt under enormous stress to safely care for patients when the ward was open to overnight patients. The ward was being used now on a very regular basis to accommodate surgery patients overnight when there was no ward bed for them. The unit was staffed through with regular use of bank or occasionally agency staff, and the supernumerary (supervisory) nursing staff working or helping with more and more clinical shifts. Staff said this meant they were not always able to get time for training, supervision, or administration tasks. This was also impacting on patients as staff said the overnight patients were getting rushed care, as the staff were also admitting day-case patients. They said day-case patients were being asked to leave sometimes before they felt fully ready. Although additional staff were provided to work shifts, staff said this did not recognise the workload or the low morale of staff.
- There were established shifts at night which did not meet recommended levels. The level of nursing staff

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established for Amesbury Suite at night was not safe and significantly failed to follow recommended guidance. Amesbury Suite was a 32-bed trauma and orthopaedic ward. During the day there was one nurse for between six and eight patients, depending on whether this was early in the morning or later in the daytime. However, at night there were only two registered nurses on duty and therefore one nurse for 16 patients. These nurses were supported by three healthcare assistants at night. None of the other surgery wards had this low ratio of registered nurses, although Chilmark Suite and Downton ward had one nurse to 12 patients, which was not at recommended levels ideal, but others had a good ratio of one nurse to eight patients. The establishment on Amesbury ward had not been particularly seen as a risk within the last skill mix review (August 2015) apart from a comment of how it was “currently under review to explore the use of twilight shifts.” Staff in the musculo-skeletal directorate had been tasked to assess this establishment, but without deadlines.

- There was a high use of bank and agency staff in certain areas. This was specifically in the main operating theatres which had a high number of vacancies and sickness absence. The main theatres were short of six anaesthetic practitioners, had three on maternity leave and two coming up to retirement. The staff were flexible and plans were being made to train operating-department practitioners to become trained in both scrub and anaesthetic roles. One member of staff was currently being trained. There were high vacancies on Amesbury ward and therefore a high use of agency staff. When we visited on 2 December 2015, three of the four nurses rostered to the daytime shift were agency staff. On our unannounced visit on Sunday 13 December there were, however, substantive staff on duty all weekend, as was the case for the other three wards and the surgical assessment unit when we visited.
- There was an induction checklist for temporary staff employed to wards and theatres. A checklist provided to us by Downton ward, for example, included an introduction to the nurse in charge; layout of the ward; procedures for use of and location of emergency equipment and telephone numbers to use; procedure for reporting incidents; review of staff being able to safely use relevant equipment; and awareness of hospital policies and protocols (such as for infection

control). There was also a comprehensive local induction checklist for temporary operating theatre staff. This included an introduction to staff, systems and procedures and ensuring a copy of the person's signature was obtained to cross-reference against prescription charts and registers.

- Nursing and healthcare assistant staffing levels (actual shifts covered by substantive, bank or agency staff) were sometimes short and not filled to safe levels, although there was a much improved position in the last six months. Ward staffing levels from March to August 2015 were provided in terms of percentages of shifts covered or not. Most of these across the various wards were in the high 90% for cover. However, in this result were some shifts where there were more nursing or nursing assistants than planned (so over 100% - and some as high as 200%) and this skewed these average figures upwards.

When looking at the detail the following shifts were below 100% staffing at some point between those dates:

- On Laverstock ward there was an average of 27% of nursing shifts and 19% of healthcare assistant shifts not filled to 100%. The problem worsened over the time-period with 40% of nursing shifts not reaching 100% in August 2015. This ward would be up to establishment by February 2016 with new starters coming into post.
- There was an average of 10% of nursing shifts and 13% of healthcare assistant shifts unfilled on Chilmark Suite. The shortage of nursing shifts had improved from 21.5% below 100% staffing in March to 9% in August 2015.
- There was an average of 14% of nursing shifts and 8% of healthcare assistant shifts unfilled on the Burns unit. As with Chilmark Suite, the shortage of nursing shifts had improved from 23% below 100% staffing in March to 12% in August 2015.
- Amesbury Suite had also seen improvements in the number of shifts being filled, although only by August 2015. Overall, there were 19% of nursing shifts not covered to 100% and 14% of healthcare assistant shifts. The shortage of nursing shifts had improved slightly from 27% unfilled to 100% in March to 20% in August 2015.

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- Britford ward had around 27% of nurse shifts and 26% of healthcare assistant shifts unfilled to 100% (this was for June to August 2015 as earlier information was not provided).
  - Downton ward performed relatively better. Around 5% of nurse shifts and 11% of healthcare assistant shifts were unfilled in the six months from March to August 2015.
  - The sickness levels within nursing in surgery services were, overall, below the NHS national average of around 4%. Data for the musculo-skeletal directorate reported 2.5% sickness absence in the year from April 2014 to March 2015, but this was higher in the surgery directorate at 4.1%. Within the larger staffing groups, sickness was higher in day surgery and theatre staff (both at 5.4%), but low on the surgery wards.
  - There were handover meetings, ward rounds and safety briefings involving the nurses each day. The safety briefing was held three times a day to review all patients and areas of concern. It included, for example, any issues with infection control; whether the ward was caring for patients from other disciplines (such as surgery wards accommodating medical patients); any staffing issues; and patients receiving specific care, such as for central lines, sepsis, or subject to Deprivation of Liberty Safeguards. The forms for safety briefings we saw were all completed and information handed over to staff. We observed they were slightly different between wards. The briefing on Amesbury Suite (where there were more complex patients) was more extensive than the briefing completed on Britford ward, for example.
- Medical staffing**
- There was good coverage from experienced and senior medical staff. The hospital had a medical staffing skill mix, which was slightly different to the England average with more consultants in post in percentage terms. Around 48% of medical staff were consultant grade (England average 40%) and there was a lower ratio of registrars (37% against the England average of 47%). There was a similar rate of foundation year trainees to the England average (16% against 15% nationally). We met a large number of consultants during our visit and found them open, honest and committed.
  - The surgery wards and services were appropriately staffed by doctors, although they were stretched at busy times, and when there were increasingly unwell patients. We met a registrar on our unannounced visit, who had a wide range of responsibilities with around 60 to 70 patients to care for including surgery patients who were in other wards. This doctor and other junior doctors we met said they felt very supported by the consultants and could contact them at any time when they needed clarification, opinion or support.
- Use of locum doctors was reported by the trust to be very low in the surgery division and across the whole hospital. In data for the previous financial year (April 2014 to March 2015) use of locum doctors was below 1% overall.
  - Consultants and doctors carried out appropriate timely ward rounds. Staff on all the wards and units we visited said the ward rounds took place twice every day. Patients we met told us they had seen a doctor every day. We observed a number of ward rounds and saw good practice. On our unannounced visit on a Sunday, staff on the wards and the surgical assessment unit said doctors came to see patients twice a day and whenever they were called for an opinion or to assist. The nurses said they were involved with the ward rounds as appropriate, and the nurse in charge would complete the whole round with the multi-disciplinary team. Staff on Laverstock unit (the plastic surgery ward) were trialling a 'paper round' (where staff sat together and reviewed the patients' records) before undertaking a bedside review with patients. This was proving relatively efficient. Staff were able to discuss various options for treatment away from the patient so as to have more decisive information and choices to bring to the patient.
  - Nursing staff and particularly the student nurses we met at a focus group said they felt well supported by the medical staff. When we visited the hospital on both the announced and unannounced visits we observed doctors reviewing patients and coming onto wards when requested by nursing staff. The doctors were working alongside the nurses and acted as a team, with a multi-professional approach to the patient. The student nurses told us they had been particularly impressed with the willingness of the medical staff to include them and encourage them to put theory into practice as much as possible. They said this built their confidence both now and for the future.
- Major incident awareness and training**

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- The trust had a current major incident plan produced originally in 2013 and updated last in August 2015. Key staff knew how to access and distribute the policy and in what circumstances it was relevant. There were other plans associated with the major incident plan, including, for example, the national burns major incident plan and the pandemic influenza plan. There were key staff with named responsibilities listed in the policy along with key locations, such as the command centre and places for relatives to stay. There were also instructions for obtaining medicines and equipment for major incidents.

## Are surgery services effective?

Good



We have judged the effectiveness of surgery services as good, although some areas required improvement. Length of stay in the hospital was good, being mostly below (better than) the England average. Patients' pain was well managed with specialist input and nutrition and hydration was well supported. There was effective assessment for patients with the risk of developing blood clots, and good work being done to get people back on their feet and home as quickly as possible. The hospital performed better than the England average in the national hip fracture performance audit, but performance had declined from the previous year. The hospital performed well in the national lung and bowel cancer audits in 2014. Post-surgery readmission rates were generally good, although this varied between planned and emergency surgery. The hospital performed relatively well in the patients' review of their outcomes following hernia and hip/knee replacement and varicose vein surgery. There was a low level of surgical site infections reported.

The hospital had, however, performed less well in the National Emergency Laparotomy Audits of 2014 and 2015. There were actions plans to address the shortcomings, but not all of these had been completed. Not all staff had been given their annual performance review and this was not meeting trust targets. There was, however, a good standard of competence among the staff teams and encouragement and opportunities for professional development. There was strong multidisciplinary working with a common sense of purpose among staff. Important services were provided

seven days a week and there were no problems with getting access to information, although the trust's database was criticised by a lot of staff for being hard to navigate. There was a wide range of policies and procedures drafted alongside best practice and national guidelines. Consent and knowledge of mental capacity was good, although there were some actions from a yearly audit which had not improved in the last two years.

## Evidence-based care and treatment

- Despite delays in discharges, predominantly for patients needing social care packages or continuing healthcare, the length of stay for surgical patients within the hospital was mostly below (better than) the England average. It is recognised as sub-optimal for patients to remain in hospital for longer than necessary and a barrier to other patients being admitted. The latest available data produced for the trust by the Health and Social Care Information Centre covered 2014.

For all elective (planned) surgery patients, the length of stay was 2.9 days (England average 3.1 days) and for emergency surgery patients, 4.2 days (England average 5.2 days). Within elective surgery there were, however, longer stays than average for patients having trauma and orthopaedic surgery (3.8 against 3.1 days) and plastic surgery (3.1 against 2.4 days), but these were offset by much shorter stays in other specialties.

In emergency surgery, trauma and orthopaedics was just marginally above the England length of stay average (8.6 against 8.5 days) although general surgery was below (3.5 against 4.2 days).

- The hospital reported a high level of compliance with assessment for patients developing venous thromboembolism (blood clots). The wards were audited each month to check completion of an assessment by a doctor of the risk to the patient from developing a blood clot. Most wards had 100% compliance in the months from April to October 2015. We also saw completed assessments in patient records we reviewed. There was a risk assessment tool for doctors to consistently determine risk. There were recognised risk factors for patients, such as obesity, dehydration, and medical history (including family history and risk of clotting). Regardless of actual assessed risk, all patients were automatically considered high risk and treated in advance



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(prophylaxis) if their surgery was expected or known to be longer than 90 minutes, or 60 minutes if the procedure involved a lower limb or the pelvis. Other assessed risks were then treated appropriately. Patients were either given medicines to prevent or reduce the risk of a blood clot, and/or encouraged to be active and maintain adequate fluid intake. There was a leaflet for patients to take home called 'Help us 'Stop the Clot'. This gave advice to patients when they went home about ways to prevent a blood clot in the three-month risk-period after surgery. It explained what things to look out for and what to do about any concerns (contact the GP). The hospital had won a national award for nurse-led services in venous thrombosis and anticoagulation services.

- The surgery services operated an enhanced recovery programme ('the programme'). This was for patients who were post-operative in a number of procedures. It included total knee replacement, colorectal surgery, breast reconstruction, stoma patients, and total hip replacement. There were information leaflets provided for patients to guide them through the programme, and how it should be delivered to them. The leaflets explained how the programme was designed to get people up and mobile as quickly as possible, to speed up recovery, and reduce the length of stay in hospital. The trust was in the process of auditing the programme for hip fracture therapy in more depth but results were not yet available. Previous reviews of the programme showed how the trust had been seventh in the country for getting patients home within three days in 2014. The average length of stay was 18.1 days compared with a national average of 19.8 days.

## Pain relief

- Pain relief on wards and theatres was well managed. Patients prescribed pain relief to be given 'when required' were able to request this when they needed it. Patients told us, and we observed, how they were asked by staff if they were in any pain and medicines were provided in line with the patients' prescriptions. One patient we met on Amesbury ward had been given spinal anaesthesia and commented upon how the procedure had been "amazing and almost totally painless. It was over before I even realised they had done anything."
- Pain was managed well for patients unable to always express themselves. The hospital was using a tool for pain assessment for patients living with dementia or cognitive impairment who may not be able to express how they felt. It involved checking if a patient was showing signs of pain from breathing patterns, facial expressions, if they cried out, whether they were anxious or withdrawn, and clues from body language. These areas were scored and actions taken if the tool showed any evidence the patient was in pain. Other information could be taken from the 'This is Me' document produced for patients with cognitive impairment to describe how they normally acted or behaved.
- Patients were advised about when pain might increase and how they and staff should respond. For example, patients who underwent emergency abdominal surgery (laparotomies) were advised they could experience higher levels of pain after their surgery. Patients were told the pain would be likely to ease after a few days, but use of strong painkillers was common during the first few days after surgery. There was a hospital pain team providing specialist input into pain management. Staff were aware of how and when to contact the team for advice and guidance. The patient information for emergency laparotomies indicated the specialist pain team would be called to best advise patients on pain management.
- There was a measurement of pain management provided to post-operative patients, although the surgery directorate accepted more work was required on measuring and managing post-operative pain. There were local audits for pain management in line with National Institute for Health and Care Excellence (NICE) guidance. For example, there was an audit against NICE guidance 173 for neuropathic pain (pain caused by damage to nerve fibres). The hospital had been compliant with all the 14 standards assessed in 2014, including considering referring a patient to a specialist; regular review; and looking at switching medicines if they were not working within a specific time. There had also been some work carried out on pain management for post-operative patients. For main theatre patients, this indicated there were far more patients experiencing a higher level of post-operative pain than the target. The results gathered from August 2014 to August 2015 stated around 20% of patients experienced a high pain score on waking after surgery. The performance target was



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5%. Staff were not sure how this target had been chosen for measuring performance of pain management in main theatres. They told us it needed further examination if it was to be a useful tool for improvement. Patients on the day-surgery unit were, nevertheless, mostly achieving the targets set for post-operative pain, which had been set as the same as those on the main theatre unit.

## Nutrition and hydration

- Initiatives had been rolled out to improve patient nutrition and hydration. The trust had a nutrition and hydration committee as part of the clinical governance structure. The group met every six weeks, and was chaired by the head of estates. An annual report was produced for the clinical governance committee. It received reports from the dementia steering group and patient food forum. A number of changes had been introduced in relation to nutrition and hydration in 2014/15. This included the introduction of blue crockery to help people living with dementia to be able to distinguish food on the plate and therefore be able to help themselves more often and effectively. Menus were improved to support patients with swallowing difficulties. More choices were added at mealtimes and choices for patients with coeliac disease were increased.
- There were innovations in nutrition, which endeavoured to support people who needed help with eating and drinking, but not make this stand out unnecessarily. The 'red tray' which had been used in the past, and is not uncommon in NHS hospitals so staff can recognise people needing support with eating, had been phased out. It had been replaced with a gold tray, which was less distinctive and therefore more subtle alongside the regular pale yellow trays. There were also green trays in use to highlight patients with food allergies or intolerance, although we did not see any of these in use.
- There was audit of patient nutrition and hydration support with some good results and areas for improvement. The nutritional audit in May 2015 identified 94% of patients were assessed for nutrition within six hours of admission. There was, however, a poor uptake in the number of patients who had been weighed (38%). Hospital dieticians had produced a campaign focusing upon raising awareness of why weighing patients was important, but ward staff admitted there was more work to do.
- There was a food and nutrition policy based upon guidance from the British Association for Parental and Enteral Nutrition. The policy guided staff to use the nutritional risk assessment tool (including both nutrition and also hydration) to monitor patients who were at risk of malnutrition. Patients were scored against their risk of malnutrition/dehydration, and plans were then developed to address the risks. Those records we saw on ward we visited were well completed.
- Protected mealtimes had been introduced at the trust to provide an atmosphere and environment more suitable for patients when eating. This limited interruptions and gave staff time to make sure people who needed help with eating and drinking were provided with that. Visitors, unless they were specifically helping patients at mealtimes, were discouraged from coming in at mealtimes. This gave patients the opportunity to also rest after a meal and equally gave visitors a break. Doctors and other clinical staff only carried out essential visits with patients. This was supported by a trust protocol on protected mealtimes.
- Patients were fasted appropriately pre-operatively when admitted as inpatients prior to their surgery although there were no tailored regimes. Therefore, all patients were given the same instructions irrespective of their place in the operating list, although this was divided into morning and afternoon regimes. Patients who came for day-case procedures were given appropriate instructions about food and drink intake before their procedure. If a patient was operated on in an emergency situation, their response to the risk of nausea and vomiting was managed in theatre and recovery either with appropriate medicines or close monitoring.

## Patient outcomes

- The hospital performed relatively well in the Patient Reported Outcome Measures (PROMs) for April 2014 to March 2015. These were patients who reported back to the hospital on their outcome following surgery for groin hernias, hip replacements, knee replacements, and varicose veins. With the four procedures, and as with the England average, almost all patients reported their health had improved when measured against a combination of five key general health-related indicators. Almost all patients having knee replacements and all those having hip replacements said they experienced improvements when asked more

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specific questions (called 'Oxford scores') about their condition. The hospital exceeded the England average for patient improvements in their health for groin hernia surgery and was much the same as what was a very good national average for improvements in health following hip replacement surgery. The results for knee replacement and varicose vein surgery for health improvements were good as well, but not quite as good as the England average.

- The hospital performed well in all measures of the national hip fracture audit, although the performance in 2014 had slipped over 2013 for four of the seven measures. In 2014 the hospital was better than the England average for patients being admitted to orthopaedic care within four hours; surgery being carried out on the day or day after admission; pre-operative review by a geriatrician; and patients going on to develop pressure ulcers. All of these measures had declined, however, when compared with the performance in 2013, which has been excellent. Particularly good outcomes were: 71% of patients admitted to orthopaedic care within 4 hours in 2014, against an England average of 48%. Also, 71% of patients had a pre-operative assessment by a geriatrician, against an England average of 52%. Both of these performance measures had, however, declined since a better result in 2013.

In two other measures, namely bone-health medicine assessments and falls assessments, the hospital had a 100% performance rate (England averages both 97%). Length of stay of patients had improved to just over 18 days in 2014 (from 21 days in 2013) which was a day less than the England average.

- There were low levels of surgical site infections reported. The hospital reported to Public Health England (PHE) post-operative infections to patients following procedures for hip and knee replacement. A PHE report then compared the hospital's results with national statistics. The hospital last reported on hip replacement statistics for April to June 2015. There were 23 patients submitted to the review in this period. None of these patients had to come back to the hospital to be treated for a post-operative infection. In data for 2013/14, there were 98 operations reported on. Of these two patients were readmitted to treat an infection. Knee replacements were last reported on for the period

October to December 2014. There were 83 operations and just one readmission for an infection. In the year 2013/14 there were 72 operations reported on. Of these, three patients came back for an infection to be treated.

- The hospital performed well in national cancer audits as they relate to surgery. In the lung cancer audit, at the high-end of the results, the hospital achieved 100% for discussing patients at a multidisciplinary level. At the other end of the results, only 86% of patients received an appropriate scan against the 91% England average. In the bowel cancer audit, the hospital also achieved 100% for discussing patients at a multidisciplinary level. It was above the England average (so better) for the other measures including patients being seen by a clinical nurse specialist, and receiving a relevant scan. The hospital was also credited for having well-completed patient data.
- The hospital did not comply with 16 out of the 28 measures for the first National Emergency Laparotomy Audit (NELA) 2014. This included there being not having an operating theatre reserved for emergency patients 24 hours a day; no formal rotas for associated interventional and diagnostic procedures (although this is not uncommon in trusts of this size); some policies not relating to the seniority of operational staff (although a number of these had since been developed); and no pathway for the enhanced recovery of emergency general surgery patients.
- In the 2015 first NELA patient report (focusing on patient outcomes), the hospital achieved the 70% target to be compliant with recommendations in only one of the ten standards. Results were between 50% and 69% compliance in eight of the others, and less than 50% compliance in the remaining one. The compliant standard was for a consultant surgeon and anaesthetist to be present in theatre. The standard failed (achieved for less than 50% of patients) was for patients over 70 years of age to be reviewed by a specialist in medicine for care of the older person. This is a common failure among almost all NHS trusts in England.
- The trust had produced an action plan following the 2014 NELA audit, but accepted this was incomplete and provided no assurance. There was, however, a NELA review presented within clinical audit documentation.

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This described a joint clinical governance meeting with surgeons and anaesthetists. This demonstrated improvements had been made since the 2014 audit including:

- All patients having an early review (within six hours) by a consultant surgeon.
- All patients were admitted to theatre within six hours of a decision to operate.
- A consultant surgeon was present at 97% of laparotomies and 100% of those performed after midnight.
- The trust introduced mortality risk-scoring and 80% of patients now had their risk calculated prior to emergency laparotomy surgery.
- Areas for improvement identified in January 2015 included (and if they had been improved by the next governance meeting in September 2015):
- January 2015: Documentation of risk was very poor. Not progressed by September 2015.
- Consultant anaesthetists were present at only 40% of laparotomies. This had improved to 80% by September.
- Requirement for an integrated care pathway. This had not yet been produced.
- Patients we met on trauma and orthopaedic wards reported good therapy services. Patients who needed active and regular physiotherapy said this was provided seven days a week. We were told the physiotherapists were good at motivating people and had a positive optimistic attitude. Some patients had also met with an occupational therapist who provided practical support to adapt to different temporary or permanent changes to a person's mobility or living arrangements.
- Patient readmission rates after surgery (due to corrective measures needed or infections) were above the England averages, showing, overall, more patients were readmitted after surgery than expected. It should be noted, however, that these statistics can fluctuate and are relatively sensitive to small numbers of patients. The data can also include patients returning for planned readmissions. However, overall, in data for July 2014 to June 2015, there were 2% more patient readmissions for elective surgery than the England average, and 18%

more than average for emergency surgery. The position for emergency surgery had deteriorated in the month of June as the rate for the period June 2014 to May 2015 was just 1% of patients readmitted. This was due to a rise in readmissions for general surgery and plastic surgery and urology.

Within the detail there were variable rates of readmission. Data for the top three elective specialties based on the number of procedures carried out showed:

- Urology surgery had 32% more readmissions over the England average. Some of these were planned readmissions for procedures such as 'trial without catheter'.
- Plastic surgery had 13% more patients being readmitted. Some of these readmissions related to a planned series of operations or wound and dressing checks.
- Trauma and orthopaedic surgery performed better with 7% less readmissions.

In emergency procedures:

- General surgery had 23% more readmissions over the England average. Some of these readmissions were related to on-going intravenous therapy, wound and dressing checks.
- Plastic surgery had 32% more patients being readmitted. Some of these readmissions related to a planned series of operations or wound and dressing checks.
- Urology surgery had 7% more patients readmitted.

## Competent staff

- The directorates incorporating surgery services (musculo-skeletal and surgery), were not meeting the trust target for 85% of staff to have had their annual performance review. Data provided to us showed that by the end of September 2015 the non-medical staff, so nurses, operating department practitioners, nursing assistants, and other relevant staff, had achieved 64% in the musculo-skeletal directorate and 57% in the surgery directorate. The compliance level was worse in the year to the end of March 2015 when 44% of non-medical staff in the musculo-skeletal directorate had received an annual review, and 39% in the surgery directorate. Senior staff did tell us, however, the current system for

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recording performance appraisal data was poor and they believed the numbers we had been given were not the true picture. All the staff we asked, which was in excess of 30, said they had their appraisal and had done so each year.

- Medical staff were evaluated for their competence, and met targets to have had an annual performance review (appraisal). This had improved significantly since it became a requirement of doctors' registration to have an annual performance review as part of the 'revalidation' programme. This was a 2014 initiative of the General Medical Council, where all UK licenced doctors are required to demonstrate they are up to date with the professional development and performance reviews and fit to practise. This is tested in part by doctors participating in an annual appraisal leading to revalidation by the GMC every five years. By the end of September 2015 the medical staff had achieved 88% on average for performance reviews to be completed. Revalidation is due to be implemented for nursing staff from April 2016.
- There were guides for newly employed staff to help orientation and induction. Downton ward had produced an excellent 'Useful Guide for New Staff' for new nurses. This described the ward, staff who worked there, and useful explanations of terms and acronyms in regular use. There was also a comprehensive local induction guide for new operating theatre staff. This included an introduction to staff, systems and procedures.
- The hospital had a number of training and development opportunities for staff. There was a development programme recently introduced for nursing assistants in the operating theatre department. The objective was for band two staff to work through an education and development programme to progress to band four. There were 23 staff now on the education programme which was being run by an experienced theatre sister. Other staff spoke of various courses and programmes they had been enabled to attend. Staff said there were no barriers to professional development as long as it was relevant to their responsibilities or their future objectives. This included a physiotherapist who said they had been encouraged and enabled to progress their career.
- There was consistent collaborative working from staff contributing to patient care, but with improvements needed in some aspects of culture within the operating theatres. There was a common sense of purpose among staff with the patient at the centre. We observed, and were told, there was mostly no obstructive hierarchical structure and staff were valued for their input and roles. Staff said, however, there was some work to do to bring fully collaborative teamwork into theatre. For patient safety, it is essential teams function effectively at all times. The collaborative and team-focused approach of use of the World Health Organisation surgical safety checklist was mostly embedded well, but there were some aspects of culture not working as well as it should. This had been recognised by senior staff and was being addressed.
- Therapy staff worked closely with the medical and nursing teams to provide a collaborative approach to patient rehabilitation. Staff and patients spoke highly of the physiotherapy care provided to surgery patients. There was multidisciplinary input involved with all patient care. The patient records demonstrated input from therapists, including dietitians, speech and language therapists, and occupational therapists, as well as from the pharmacist team, the medical team, and diagnostic and screening services.
- There was evidence of a strong multidisciplinary approach contained in national cancer audit results. In the 2014 bowel cancer and lung cancer audits, there was 100% compliance with there being a multidisciplinary discussion in the 228 cases reviewed. This was above the England average of 99.1% in the bowel cancer audit and 95.6% in the lung cancer audit.

## Seven-day services

- Cover out of hours for anaesthesia was appropriate to the service. There had recently been some changes to the anaesthetic cover as the trust had opened the obstetric theatre in the maternity unit 24 hours a day. This unit was located in a different part of the hospital from the main theatres and a three-minute walk away (we estimated). Before implementing the change, a study had been done to model the anaesthetic cover with staff now no longer being within the same main theatre location. The quantifiable risk of the change had been measured as negligible, although some staff were not yet convinced about the recent change. The clinical

## Multidisciplinary working

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director, who we found was open to hear concerns and listen to staff, had decided to review the practice again at the next clinical risk meeting. There had, however, been no impact on patients from one of the night-time doctors working on occasions physically further away from the main theatres as in the past.

- There was good support from consultants on call out-of-hours. Registrar and junior doctors told us they had good support from them either by telephone, or in person when this was needed.
- The trust provided serious emergency surgery services around the clock. There was a surgery team on site 24 hours a day with support and specialist surgeons on call and able to attend the hospital within 30 minutes. Surgery after midnight was only that described as 'life and limb' and therefore in order to save life. The hospital sterilisation and decontamination services also operated seven days a week to provide services to theatres and elsewhere. The surgery wards were open and admitting patients seven days a week around the clock and the surgical assessment unit was open for referrals seven days a week from 8am to 8pm.
- As well as the 24 hour emergency theatre, there were two operating theatres open on weekdays and weekends from 8am to 6pm for emergency daytime surgery. One theatre was for trauma and orthopaedic surgery, and the other for plastic surgery which usually covered orthopaedic and plastic surgery, and the other for more general surgery. The theatres operated from 8am to 6pm. The service is supported by a consultant anaesthetist, a specialist registrar, and a core trainee in anaesthetics a foundation year two doctor or specialist registrar year one.
- Access to clinical investigation services was available across the whole week. This included X-rays, MRI scans, computerised tomography (CT or CAT) scans, electroencephalography (EEG) tests to look for signs of epilepsy, and echocardiograms (ultrasound heart scans).
- There were arrangements for the supply of medicines when the hospital pharmacy was closed. A pharmacist was also available on-call out of hours.
- Therapy staff were available in person or on call across the whole week. If therapy staff were off duty, there was access to certain staff out-of-hours through on-call

rotas. Otherwise, therapy staff (including occupational therapists, speech and language therapists and dieticians) were on duty on weekdays, and physiotherapists worked seven days a week.

## Access to information

- Patient records were well managed. Almost all records were on paper, although one ward was trialling an electronic patient-record system. Staff said they had rarely experienced notes not being located as required. The notes were held in an electronic booking system, which tracked them when they moved around the hospital. Staff in the pre-operative assessment unit showed us how records they needed had been recorded as being moved to the unit. These would be the returned to the record store, or to wherever they were next needed and the move recorded electronically.
- Access to patients' diagnostic and screening tests was good. The medical and nursing teams said results were usually provided quickly and urgent results were given the right priority.
- There was criticism from a number of staff in different roles about finding information on the trust intranet. The system, known as ICID: Integrated Clinical Information Database had a wealth of information much of which could be accessed by staff, and also the public. There were policies, care pathways, information leaflets and clinical guidance. Staff concerns were with the search facilities. They said unless you knew the exact title of the guidance or information you were looking for, it was very difficult to locate the information.

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

- Patient consent was well managed and appropriately documented. Patients we met all said they had signed consent forms following a discussion with the doctor. They had been given the opportunity to ask questions and told the advantages and risks of the process they were about to undergo. For some procedures, such as taking blood samples or general tests, specific written consent was not required. However, patients would be required to give implied or verbal consent. Those patients we asked said they were always asked for their permission for any procedure. One patient said staff would say: "I am going to need to take your blood pressure, is that OK?" Another patient said the nurses



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always told them what medicines they were being given and why. In order to help with making consent decisions, the day surgery unit had developed consent forms to send to patients in advance for certain procedures. There was a helpful form with detailed information, for example, for patients undergoing a bladder examination (rigid cystoscopy). The version we saw had not yet been updated. It was produced in October 2011 and due for update in October 2014.

- Consent was being done well in practice, but records needed improvement, and those areas recognised as weak in 2013 had not improved in 2014. Consent had been audited by the trust to make sure it had been sought and provided in line with the trust policy. There were some good results and some were in need of improvement.
  - In the 2014 audit, the correct form had been used in 100% of cases reviewed (130 records were checked).
  - All patients had signed the form where this was appropriate and 100% of forms had been witnessed where this was required.
  - The type of anaesthesia to be used was recorded on 86% of forms.
  - However, there were some poor areas of compliance. For example:
    - Only 61% of forms had the name of the healthcare professional responsible for the patient. This had deteriorated following a 70% result in 2013.
    - Only 56% of forms had the person's job title (64% in 2013). This was particularly weak in general surgery and orthopaedic surgery.
  - Another area of weakness was with the requirement for the person completing the consent form to include their contact details. This had only been done in 15% of the forms. This was down from 20% in 2013.
  - Also, only 20% of forms recorded whether the patient had been given a copy of the form.
  - There was an action plan attached to the consent audit, and comments as to how it would be discussed at departmental clinical governance meetings. The audit was undated, but appeared to have been completed in August 2014. Although we
- did not have all clinical governance meeting minutes, those we were given did not include any reference to this topic being presented and actions agreed at local or directorate level.
- There was a standard policy for consent. This covered why consent was legally required, and who was competent to provide it. The policy gave staff guidance on consent for standard procedures, and went into detail on consent for tissue storage, use and disposal, and clinical photography and video/audio recordings.
- The hospital had documents and processes for assessing a patient's mental capacity, competence to make their own decisions, and what to do if that was lacking. Those forms we saw in patient notes were completed as required. There were specific forms for use in the event a person did not have the mental capacity to make their own choices. This was referred to as 'consent form 4'. The form required the healthcare professional to confirm how they had determined the patient did not have the capacity to consent. It went on to show how the decision had then been made which was deemed in the best interests of the patient and involvement from the patient's family or those close to the patient. The trust policy described well how a decision taken by a patient was specific to the procedure in question. Patients could also regain their capacity, and the policy made it clear the decision was for that specific time and not for all future decisions. It explained how a patient may be able to take some decisions, but more complex ones would require a best-interest decision. Staff were given a useful reminder about how consent would be seen from the perspective of the patient.
- Among those staff we spoke with there was a good understanding of Deprivation of Liberty. Staff had been trained to have a working knowledge of Deprivation of Liberty Safeguards, and when to apply them. One of the occupational therapists we met had a clear and intelligent understanding of this subject as well as the Mental Capacity Act. The trust had provided guidance around what actions would amount to a Deprivation of Liberty, and how to proceed to have the deprivation approved. There was a decision-making tool on the trust intranet for staff to follow if there was a situation or potential situation where a deprivation would occur. There was guidance for staff to follow to apply for an



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authorisation to deprive a patient of their liberty, and what to do if authorisation was not given. On those wards we visited on our inspection, there were, however, no current records to review.

## Are surgery services caring?

Good



We have judged the caring of the surgery services as good. Feedback from patients and their families had been almost entirely positive. If there was criticism, this was not around the care provided by the staff, but the time the nurses, practitioners, and nursing assistants had to provide care and support. This was echoed by the staff themselves. The Friends and Family Test produced excellent results. Patients we met in the wards and other units spoke without criticism of the compassion, kindness and caring of all staff. Staff ensured patients experienced dignified and respectful care, and worked hard to promote patients' individuality and human rights.

Patients and their family or friends were involved with their care and included in decision making. They were able to ask questions and raise their anxieties and concerns. There was, however, some criticism of communication with patients who were waiting for procedures. There was access to chaplaincy services and support from nurses and doctors with specialist knowledge.

### Compassionate care

- Patients spoke almost overwhelmingly of the kindness of the staff. Patients on Downton ward made comments like: "I have been treated so well", "they speak so kindly to me", and "they look after you so well." We observed staff knocking on doors before entering rooms, addressing patients by their preferred name, and getting down to the level of a patient to talk with them. On Chilmark Suite, patients said staff were "all a different personality, and each one brings a different talent." We were told all staff introduced themselves to patients. A patient said: "I obviously did not want to be here, but despite that, it's been a pleasure." Another patient told us they did not like the bay being really dark at night as they were nervous of the dark. They said staff made sure the low wattage light over their bed was on at night to make them more comfortable. Other patients said it was

a dim light and did not cause them a problem. On all the wards and units we visited, we heard positive comments about the care they received and the kindness of the nursing staff. On our unannounced visit, a patient in Chilmark ward said of the hospital: "sometimes I mistake it for a five-star hotel." The same patient had visited other services within the hospital for various tests and said: "no matter where you go in the hospital the staff are excellent."

We have written above about how a number of patients we met were concerned about nursing-staff levels. We heard numerous concerns about staff being "rushed off their feet" and "just doing too much." We heard, nevertheless, how staff were very caring for patients. The comments about patients having to wait too long for staff to assist were balanced with staff who we saw:

- Helping a patient who was going home to pack up their belongings neatly and tidily into bags.
- Gently helping a patient who was confused to arrange their bed clothes to preserve their dignity.
- Giving reassurance to a patient with a learning disability who was going for a day-case procedure.
- Being cheerful and encouraging with a patient who was recovering in the main theatre recovery area. The patient, who was fully awake from their procedures, said they had got to know the staff and "they are wonderful."
- Patients remarked upon the commitment and individual approach of the doctors. One patient who had been in the Burns Centre for a number of weeks said they thought the care of the consultant was "outstanding". They said the consultant had visited them regularly both in the daytime and in the evening to check if they were okay. They said the care by both the nurses and the medical team in terms of time given to them could not have been better. Another patient on Chilmark ward said their consultant had been honest but also firm with them to make sure they understood how to respond to treatment and advice so they had the best chance of recovery. A number of patients told us how they had great faith and trust in the consultants and junior doctors.
- We observed good attention from all staff to patient privacy and dignity, although the recovery areas in day-surgery were not ideal. Any patients we observed in the operating theatres were fully covered in all preparation and recovery rooms, and when returning to

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the ward areas. On wards curtains were drawn around patients, and doors or blinds closed in private or side rooms when necessary. There were privacy screens provided in the surgical assessment unit to improve confidentiality. There was one area where privacy arrangements were not ideal. This was in the two recovery areas in the day-surgery unit. One was a small and cramped four-bedded area where patients were on trolleys in a line with curtains separating them. This meant confidentiality could be an issue, as there was no audible privacy. Patients able to or needing to be moved would have to be moved past the foot of the trolley of another patient if they were in the inner area of the unit. Staff said they endeavoured to use this area as efficiently and sensitively as possible, but with a busy department, this was often a challenge. The other was a small area separated from a corridor by a curtain. This area could be used for two patients, but there was no curtain available to provide any privacy in those circumstances – which staff described as rare.

- The NHS Friends and Family Test results for the surgery wards and units showed excellent results. Patients were asked to say if they would recommend the ward to their family and friends. In the six months from April to September 2015, 97% of patients were either 'extremely likely' or 'likely' to recommend their ward to family and friends. The test was responded to by an average of 37% of those patients admitted (2,480 patients). The individual ward details for September 2015 (the latest available data) were:
  - Amesbury Suite (trauma and orthopaedics) would be recommended by 99% of patients (response rate of 56%).
  - Britford ward (general surgery and urology) would be recommended by 97% of patients (response rate of 65%).
  - The Burns Centre would be recommended by 100% of patients (response rate of 26%).
  - Chilmark Suite (trauma and orthopaedics) would be recommended by an average of 90% of patients (response rate of 78%).
  - The day surgery unit would be recommended by 98% of patients (response rate of 23%).
  - Downton ward (general surgery and urology) would be recommended by 100% of patients (response rate of 21%).

- Laverstock ward (plastic and oral surgery) would be recommended by 100% of patients (response rate of 42%).

- The trust scored well for patient privacy and dignity in the Patient-Led Assessments of the Care Environment (PLACE) surveys in 2013, 2014 and 2015. The results had been relatively stable in the last three years and were 89/100 in 2015. This was against the England average of 86.
- Comments made about the staff in more direct patient feedback comments were almost always positive. Of the 105 comments made about staff in the feedback for May to July 2015 in the musculo-skeletal directorate, 82 were positive. Of the 33 comments in the surgical directorate, 26 were positive. Written comments included: "My stay has been brilliant. Staff are wonderful", "Lovely ward – smiley, happy and chatty staff. Really happy here. Never had a bad experience" and "Staff always have a smile of their face."

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

- Friends and relatives of patients were kept informed and involved with decisions when appropriate. Relatives and close friends of patients we met said they were able to ask questions and could telephone the wards and departments when they were anxious or wanted an update. A comment from a patient in the direct patient feedback survey carried out on Downton ward was: "The doctors were very good and explained everything to my son, even using a model, and he explained it to me. The doctor and staff are absolutely wonderful. Nothing is too much trouble." Another comment was: "Most of the staff are very good about explaining everything."
- Patients were given time to ask questions about their procedure and address any anxieties or fears. The nurses in the pre-assessment clinic, for example, demonstrated a level of understanding of their patients' potential to become anxious, even with day-case procedures where the operation was less of a risk or complexity. To help support anxious patients or those who might be unable to absorb all the information being given to them, families or carers were able to accompany the patient when and where it was safe and appropriate to do so.
- We met some patients who felt communication with them could have been better. This was one of the top themes in complaints made to the trust. One patient

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had been admitted through the emergency department with a fracture. The patient and a relative who was with them said they had been told at numerous times over two days they were being fasted before surgery. They eventually were operated on in the third day since admission, but had not eaten prior to this for two days. Another patient said they been seen in the pre-operative assessment clinic in June 2015 and then not heard anything further. They had called the hospital three times without any progress before getting an appointment for an operation the following week. They said this had been really hard on them for the last six months and they now had to prepare for an operation with almost no notice.

## Emotional support

- There was access to a team of chaplains for people of all faiths or none. The chaplaincy team were available in working hours and then on call 24 hours a day all year round. There was a chapel for people to use which was described on the trust website as “for quiet reflection and prayer.” There were regular services in the chapel and advertised on noticeboards throughout the hospital. Chaplains also visited patients and families on the wards by request and were highly regarded by staff on the wards and units. When we visited on our unannounced inspection, there was a service led by the chaplain and attended by patients in the chapel.
- The need for emotional support was recognised and provided in certain situations. For example, there was emotional support provided to a patient we met at the Burns Centre. They spoke with us about this and said how the nurses had recognised the patient needed some support with how they were feeling. A psychologist came and spoke with them. Consequently, the patient said they were able to feel they were not alone with how they were feeling and it was fairly normal. They described the care as being individual and taking into account the whole person and not just the injury. Wards used the Hospital Anxiety and Depression scale (known as the HAD scale) to review a patient’s emotional state. Staff said they were able to get support from the mental health team if a patient needed support for anxiety or depression.

## Are surgery services responsive?

Requires improvement



We have judged the responsiveness of surgery services as requires improvement. This was due to the hospital not resolving the conflict between meeting targets for patients to have treatment and putting undue pressure on services to perform to the detriment of patient experience and staff stress. There were many good aspects of responsiveness in the surgery services, not least the meeting of referral to treatment times, low rates of cancelled surgery, meeting people’s needs for information, listening to them and responding to their complaints.

But the pressure for beds within the hospital meant: too many patients were being discharged home from the main theatre department after a long wait in recovery; long waits for emergency surgery; patients were being moved to the day surgery along cold corridors either to be accommodated overnight, or to be checked before then going home; and there not being a bed available in the main wards so patients being accommodated in the day surgery unit when this facility was not designed for overnight accommodation. There were delays, changes to surgery lists and cancellations resulting from holes in drapes used to wrap surgical instruments, and some surgical sets not being available at the right time. The flexibility of the surgery teams was limiting the impact on patients, but some of this was easily resolved with better planning and communication.

Patients were complimentary about the food and drinks served, and there was some very high praise for the quality and variety of the food. People who needed more support coming to hospital were well looked after. This included those without English as a first language, or other communication needs, but there were no specialist nurses to support patients with a learning disability or staff caring for them. Staff were kind and patient with people with dementia, but there were limited facilities on the wards, such as easy to read signage and dining areas being used to help frail confused patients. There was promotion of support groups for patients and carers, and an excellent range of leaflets and information provided. There was an excellent practice in relation to staff with link or champion roles. Both nurses and nursing assistants were assigned together to be links or champions of certain aspects of patient care and support.

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

- Surgery services at Salisbury District Hospital were established to meet the needs of local people, but also the wider community. This included providing emergency and planned surgical services to patients needing the most common procedures such as trauma and orthopaedic (including hip and knee replacements), general surgery and urology. The hospital was also funded by local clinical commissioners as the regional centre for both burns surgery and plastic surgery.
- The hospital accommodated surgical patients in the day surgery unit when there were no other beds available, although this area was not designed for this purpose. There was a protocol for staff to follow saying which patients could be admitted to this area for an overnight stay and which would not be suitable. So patients who were not fully mobile, or needed packages of care at home, were not to be considered. If a patient lived with a severe systemic disease which was otherwise not incapacitating, they could be admitted but with the assessment and approval of a consultant anaesthetist or consultant surgeon. There were 101 patients cared for in the day-surgery unit in November over 18 nights. In 2015 to date, there had been 508 patients in total over 63 nights on the day surgery unit. This was not a new situation for the hospital and staff said it had been happening now for many years and now felt like a normal solution to a growing problem of bed capacity. In 2014 there were 775 patients in day surgery over 92 nights. Staff said they were demoralised by not being able to function as a proper day-surgery unit. A member of staff said they were “emotionally exhausted” due to feeling they were treating patients like “they were somehow second class.”
- Although use of the day surgery for overnight stays was not ideal for patients, there were reasonable facilities. Patients would be accommodated in single-sex areas; there were toilets that could be designated then for single-sex use; there was a shower and a disabled toilet; and the normal facilities of the hospital such as physiotherapists, pharmacists, security, food and drinks, and laundry would be arranged to supply the day-surgery unit. However, the unit was some distance from the main hospital area and staff said they felt remote at night, although knew the spinal injuries unit was not too far away.
- There was some poor planning in the availability of sterile surgical instruments. Combined with holes in some of the drapes used to wrap equipment (discussed above in the Safe section) was the occasional lack of trauma equipment, which had not been processed in the sterilisation service. For example, emergency surgery on 12 December 2015 required specific cannulated screw sets. Only one set of these was available in theatre, but two were needed. The second procedure was delayed by three hours and the order of operations changed so as not to cancel other patients while another set of screws was prepared. Another procedure was cancelled the following day due to the right size screws not being available. Delays to this type of surgery run the risk of the outcome for the patient being compromised, particularly with younger people. The holes in drapes wrapping the surgical sets also caused delays to surgery and cancellations to procedures.
- The hospital chose not to run a dedicated emergency operating theatre, which was reasonable in terms of the population and services provided. However, some patients had to wait a long time for emergency surgery. We reviewed the operating list for emergency patients for 4 December 2015. There were 26 patients on the list. Of these, 15 had been waiting more than 24 hours. At the top end of the scale were three patients waiting between 94 and 182 hours. Although these patients were classified as emergency, the list reviewed did not have any patients who were of a high priority and therefore at unacceptable risk. The emergency operating list included patients waiting for surgery who were not yet ready for their procedure and would be taken to theatre when their clinical condition was
- Patients were safely admitted for surgery. Patients were admitted to main theatres through a dedicated surgical admissions lounge. This was an area adjacent to main theatres and prepared patients for their procedure by dedicated staff. Up to 30 patients could be accommodated at any time in this area. Day-case surgery patients were admitted through the self-contained unit. The unit received patients for two lists: one in the morning and the other in the afternoon. Patients were met by a receptionist who booked them in. They were then met by staff and taken to the most appropriate part of the unit for their procedure.

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- The hospital was meeting or close to NHS England consultant-led referral to treatment time (RTT) standards in the seven reportable surgical specialties. Of late, the hospital performance had dropped slightly. When taken as an average based on the number of patients, in August 2015 (the most recent published data) the referral time for patients waiting to start treatment within 18 weeks was 94.1% against the NHS operational standard of 92%. The trust was meeting referral times in August 2015 for general surgery, ear, nose and throat, ophthalmic, and oral/maxillo-facial surgery. It was just below for urology, trauma and orthopaedic, and plastic surgery, but over 90% in those specialties.
- Looking back at this financial year, the hospital had been meeting all RTT standards in April and May 2015, but saw general and urology referrals drop below the 92% standard in June. The position had recovered for general surgery by August at 92.8%. Urology had improved, but was still slightly below standard in August 2015 at 91.7%. Plastic surgery waiting times dropped to 91.4% in July and dropped again to 90.8% in August. Trauma and orthopaedic referrals had dropped to 90.9% in August 2015, which was the first time below 92% in these five months.
- Some waiting lists for treatment were increasing while others were reducing. Overall, since April 2015, the waiting list had grown by 2.6% or 194 patients. Incomplete pathways (patients waiting to start treatment) had improved by August 2015 for some surgical procedures, but had increased for others. There were 433 patients waiting for general surgery, up from 399 in April 2015. There were 732 patients waiting for urology surgery in August 2015, which was up from 639 in April. Patients waiting for trauma and orthopaedic surgery in August had increased to 1,786 from 1,660 in April. The waiting lists for ear, nose and throat, ophthalmic and plastic surgery had, however, fallen overall by 4.3%.
- The hospital was performing as well for average waiting times as others in the local area. Average (median) waiting times for patients for surgery were the same on average as those for the South of England NHS Commissioning area. In August 2015, the South of England average waiting time was seven weeks. The average for the six specialties at Salisbury District Hospital (in terms of how many patients were waiting to start treatment) was also seven weeks. There was some variation in the detail. Oral surgery patients only had a 7.7 week wait in Salisbury but 10.3 weeks in the South of England area. The average for the South in trauma and orthopaedic surgery (the largest of the specialties) was 7.1 weeks, but eight weeks in Salisbury.
- The number of operations cancelled at the hospital for non-clinical reasons was below (better than) the England average and all eligible patients had been treated within the next 28 days. In quarter one of 2015/16 (April to June 2015: the most recent available data) the hospital cancelled 95 elective operations (of those operations meeting the NHS non-clinical cancellation criteria) compared with an average of 134 nationally. When looked at in terms of the number of elective procedures, the rate was slightly higher than the NHS England average with 1.4% of all elective surgery admissions cancelled at Salisbury District Hospital, compared with the national average of 0.9%. The percentage of cancelled patients not treated within 28 days of a cancellation was, however, exceptional. There were no patients in the period from April 2013 to June 2015 not being operated on within the next 28 days.
- Although cancelled operations were below average, the number cancelled for non-clinical reasons each month had increased sharply at one point. Operations cancelled in the period July 2013 to June 2014 were around 62 on average each month. In the year from July 2014 to June 2015 the average had increased to 92 a month. Staff we asked we not able to tell us why this might have happened, but did not recall any specific incident or decision taken that would have affected this.
- The trust had links to a number of organisations to provide additional support to patients and carers. This included local carers' support groups, advocacy services, drug and alcohol support, and links to national charities such as the Alzheimer's Society and Diabetes UK.

## Access and flow

- There were too many patients being discharged home directly from the main theatre recovery area following surgery, or on to the day surgery unit for eventual discharge. This was now around 10 patients per week. Staff said this was done with the best intentions in order not to cancel surgery, but this was not meeting the needs of patients. If patients were able to be discharged home from the main theatres, this would suggest these patients were not being operated on in the right



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location and should be day-case patients. Staff on the day-surgery unit told us there were patients who were day-case being operated on in the main theatre. They said staff there were not trained or experienced (as they did not need to be) with getting patients recovered and home on the same day, and did not have the recovery facilities for this. The operating list for the morning of 3 December 2015 showed at least five patients who were probable day-case patients. The main theatre was looking to discharge them through the day-surgery unit. We looked back at records and on 17 November 2015 there were 11 patients and on 1 December 2015 eight patients transferred from main theatre to the day-surgery unit for discharge, and this was clearly not uncommon. Similarly there were patients being operated on in the day-surgery unit who were not day-case patients and were being planned for an overnight stay. Staff said there was not any useful data on this being collected but gave us a range of recent examples from operating lists.

- Occupancy levels were increased by people unable to be discharged. There were a high number of patients who were fit for discharge, but remaining in the hospital. The data about delayed transfers of care was for the whole hospital (so included medical patients) but would have an element of surgery patients. There were around 31% of patients in the period April 2013 to August 2015 waiting for support to be provided at home before they left the hospital. A further 35% were waiting for placements in a residential or nursing home.
- Although the data is for the whole hospital, there were limited multiple moves of patients and moves of patients at night. In the period from August 2014 to October 2015, the highest number of patient moved more than three times was four patients in December 2014 and in May 2015 (0.12% of total admissions) and 0.08% of all patients overall. Patients moved more than two times affected 0.25% of patients over this period. In terms of the time patients were moved, between October 2014 and September 2015 there were around 150 patients moved between 9pm and midnight (0.5%). This then dropped to around 105 patients (0.3%) moved in the eight hours between midnight and 8am. Evidence supplied by the trust indicated around two-thirds of these patients were medical patients, and the remainder would have therefore been surgical patients.

## Meeting people's individual needs

- The majority of patients complemented the food. The Patient-Led Assessments of the Care Environment (PLACE) surveys said the hospital had significantly improved for food provision. The score had improved from 68/100 in 2013, to 83 in 2014, and was 95 in 2015. This was against the NHS England average of 88 in 2015, and 2015 was the first of these three years where the hospital had been better than the NHS average. In the more direct feedback from patients on the wards, comments were, however, not always favourable. Of 184 patient surveys in the musculo-skeletal directorate in May, June and July 2015, 52 held negative comments about food and 78 were positive (the rest did not comment on the food). Of 58 patient surveys in the surgical directorate in May and June 2015, 18 had negative comments about the food and 14 were positive (the rest not commenting). Having said that, some of the positive written comments included: "very tasty food – feel like I am in a hotel", "Excellent choice of food", and "Very pleased with the quality of the food." All the patients we met were complementary about the food and made comments including: "it's changed my perception of hospital food for the better", "really impressed with the food", and "I like how I can ask for a small portion as I don't feel much like eating and that's something they seem to have recognised, which is great." Another patient said how impressed they were with the vegetarian food options and how there were well thought-out alternatives each day.
- The trust changed menus each season and ninety-five percent of food provided to patients was produced on site. Wards had pictorial menus to help people make choices.
- The hospital had significantly improved in patient views of the environment and facilities in the PLACE survey. The score had improved from 80/100 in 2013 to 93 in 2014 and in 2015 was 95. This was against the NHS England average of 90/100 for 2015.
- Most patients had access to entertainment systems, although these were not free to access. Bedside equipment provided access to television, the internet and radio. There were no entertainment facilities in the day surgery unit, although patients who were staying overnight were able to watch television in one of the waiting areas once day surgery had finished for the day, and if they were well enough.
- There were limited facilities for providing the escalating number of patients who were delayed in leaving the



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recovery area with something to eat and drink. The manager of the recovery team said this was of particular concern. There were also no toilet facilities for patients, and some were waiting seven or eight hours at times to be discharged.

- Patients with additional or extra needs were supported for their admission to hospital. Advanced arrangements could be made for a patient with a learning disability to make their visit to the hospital easier for them and any carers. Staff on the day-surgery unit said this had included arranging a 'walk-through' of the operating theatre for a patient and their carers which was found to be helpful. Patients were also able to use quiet rooms or given early appointments so they could be seen first. The trust had a policy for adults with a learning disability attending hospital. There were links for staff to approved 'easy read' documents at the British Institute of Learning Disabilities, the University of Birmingham and Bristol University. The hospital did not, however, have a specialist nurse or a team of staff trained to support people with learning disabilities and staff looking after them at the hospital.
- The hospital had produced 'Care Cards' for patients with specific requirements. These yellow credit-card size cards could be ordered from the hospital and presented to staff to highlight different needs. There was a leaflet available to provide to patients or carers to order a card. The card did not contain personal information, but would direct staff to check the patient's records to check what specific needs the patient had. The patient might have impaired hearing or vision, for example. The card had space for or carer to record an emergency contact number or a note of the identified need if the patient agreed to record this.
- Patients living with a dementia who came to the hospital were generally well supported, although advance information about their condition was not always available, and training uptake in dementia care was poor. In relation to advance information, for example, staff in the pre-operative assessment clinic said they had met with patients who were living with a dementia and this was not clear in their notes, or known about in advance. In one case, the staff had been able to get advice and support from the patient's care workers about how to communicate best. We met with the trust lead for dementia and a consultant in elderly medicine and dementia. One of their main concerns was the poor uptake from staff in ward-based dementia training, which was offered to staff on the wards in bite-sized sessions of 30 minutes. The most often offered excuse was staff were too busy. Staff were therefore doing their best with stretched resources to support patients living with dementia. The surgery wards did not, however, provide any specific prompts or much more than enhanced signage to assist people living with dementia. There were some places for people to sit other than by their bed, but we did not see any patients using these areas for meals, for example. Patients were not able sit together at a table to eat, when it has been recognised this would often be a trigger to help confused patients to eat and drink. Communal corridors were very similar and plain with no triggers to help orientation. There was, however, plenty of light on the wards to help with reduced vision or light perception.
- Hospital staff had developed a support group for patients suffering burns or undergoing plastic surgery. The trust facilitated a charitable organisation to provide support patients who had suffered burns. The Burns Unit Support Group (BUGS) was founded in 2000 by staff at Salisbury District Hospital and a former patient. The group was run voluntarily and now included a wider group of patients under the care of a plastic surgeon. The support group provided a range of help including practical and professional information, discretionary grants for research, funding for various projects and events, and emotional support.
- There was an extensive range of leaflets and information sheets in many areas of the hospital. This included pre- and post-operative care information, including for total knee and hip replacements, spinal surgery, skin-flap surgery; care for injuries such as burns and broken bones; and how to improve self-care to avoid risks of, for example, blood clots and pressure ulcers. Information leaflets extended to more specific conditions, such as 'trauma pain management in the drug dependent'. The day-surgery unit had an extensive range of information for patients to take away following any procedure. Before patients came to the day-surgery unit they were given a booklet with information about preparing for an appointment, taking medicines, contacting the unit, what to bring, and what will happen on the day of the operation. There were helpful maps of the hospital on notice boards, printed information, and the trust website. The majority of patient information and leaflets could also be obtained from the trust website.

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- The hospital trust provided translation services where this was needed. The trust had engaged third-party services providing face-to-face and written translation and British Sign Language. These services were available during the week in the daytime. There was otherwise a telephone translation service available 24 hours a day.
- There was excellent use of nursing and healthcare staff in link roles. These were staff on wards and units who were given roles in certain aspects of care and support. Where possible they were enabled to link with hospital lead nurses or doctors to be part of a network of support. On Downton ward, for example, there were both nurses and nursing assistants partnered with link roles. These included among others, infection control, tissue viability, falls, diabetes, nutrition. Each role had responsibilities attached to it, which had been helpfully written into a protocol for staff. The responsibilities included attending link meetings, cascading information to all ward staff, completing and signing-off staff competence, auditing performance, and championing certain care bundles and pathways of care. There was a similar process on Britford ward with nursing and healthcare staff partnered in taking the lead on subjects like Deprivation of Liberty, dementia, pain and medicines.
- Patients were treated without discrimination through the use of staff mandatory training and some, but not all, policies assessed and approved for equality and diversity. The complaints policy had been ratified for quality and diversity, as had the food and nutrition policy, but the consent policy we were given did not have a written review of any discrimination within the policy. Where the policies were reviewed this had included there being no barriers to patients on grounds of sex, race, religion of belief, sexual orientation, marriage or civil partnership, disability, pregnancy and maternity, gender reassignment, or any additional characteristics important to the policy. From talking with staff and hearing about the patients who had been admitted to the hospital, there was no evidence of any discrimination on any of the above protected characteristics. The lack of any discrimination extended to any visitors to the unit, who were given full access rights while required also to act in the best interests of

the patient. Staff spoke about respecting people's wishes, rights and beliefs. They were able to describe a wide range of different needs and talked about patients' individuality and right to be different.

## Learning from complaints and concerns

- The hospital provided a Customer Care Team to deal with concerns and complaints (and compliments). There were leaflets about the service available in wards, units, and relevant areas for patients or their relatives/friends. This included how to raise a concern, who to contact and when they were available. Details explained how the complaint would be handled and what a complainant could do if they were not satisfied with the response. Patients were also told of their rights, in that they were entitled to a copy of any letter written about them. The leaflet was available in different formats and languages upon request.
- Customer Care reports were presented in detail to the trust board each quarter with an annual report each year. These reports highlighted how many complaints had been received, if targets were being met for a response, along with the trends in complaint topics. The reports gave examples of improvements made following complaints. In the most recent published quarterly report for April to June 2015, all complaints (which were those for the whole trust) had been initially responded to within three working days. The majority of complaints (88%) had a full response within 24 days. Other complaints had more complexity or required meetings to be held before they could be considered as closed. For the musculo-skeletal directorate there were 21 complaints, which was much the same as the number received in the previous two quarters. Complaints had increased in the surgery directorate, but many of these were related to issues with outpatient appointments. To put the numbers into context, there were 21 complaints in the musculo-skeletal directorate out of over 18,000 patient activities and 22 complaints in the surgery directorate out of over 16,000 patient activities. Concerns amounted to 27 and 37 respectively, and there were 121 and 81 compliments received. In the annual report some of the actions taken following complaints included the recognition of the use of face-to-face meeting; staff attitude addressed through appraisal and performance management; and improvements in response to call bells, which was an item on the risk register.

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- Complaints were discussed in departmental meetings to look for trends developing in themes or areas. Information was provided at meetings to review complaints by division or specialty and then at the themes from the complaints. The information covered the last three years, so improvements or deteriorations could be seen. One of the developing themes in surgery services was with appointments and this had been raised on the directorate risk register.
- We reviewed a complex complaint from a patient in relation to issues of consent. We reviewed the response of the trust, which had followed the complaints policy and procedure. There were face-to-face meetings, and an unreserved apology made for some clear areas where things could have been done better.

## Are surgery services well-led?

Good



We have judged the governance of the surgery services overall as good with some areas requiring improvement. There was an effective governance structure, although some of the notes from meetings within divisional teams needed improvement. The majority of risks, incidents, audits, complaints and quality performance indicators were presented to directorate management, reviewed and discussed. There were actions and learning, but this was not always demonstrated through minutes. There were some audits not included as standing agenda items, such as the surgical safety checklist, and surgical readmission rates, although most others were presented and discussed. The two surgery divisional teams had recognised and addressed some of their shortcomings, such as use of the surgical safety checklist, and acted to bring in best practice.

There did not appear to be a strategic vision for the future of surgery services. There were some plans, based around what was required by NHS England and Monitor for 2015/16, but this was individual service development rather than an overarching strategic plan. The divisional risk registers needed to define clear actions and demonstrate their progress.

There was committed leadership of surgery services. This was at both ward and unit level and with the leadership teams. All the staff we met showed dedication to their patients, the place they worked, their responsibilities, and

one another. There was a strong camaraderie within teams. We were impressed with the loyalty and attitude of the staff we met. However, despite a dedicated and caring workforce, the workloads from incorporating high use of agency staff and many new staff were causing staff stress and anxiety, which had not always been recognised. There was a high level of engagement with the staff and public. The hospital valued direct feedback from patients, which was more detailed and specific than the NHS Friends and Family Test. Staff were recognised through awards given by the trust at the hospital for many things, including dedication, innovation and being caring.

## Vision and strategy for this service

- From information we were given, we could not determine a longer-term vision and strategy for surgery services beyond what was requested by NHS England the NHS foundation trust regulator, Monitor. These future developments were service specific developments over 2015/16. There was no overarching strategy looking at innovation, sustainability, improvements and service design for, say, the next five years.

## Governance, risk management and quality measurement

- There were mostly good arrangements for governance and risk management although some inconsistency in quality of meetings and the notes produced. Many audits, incident reports, and other quality information was being received and reviewed at clinical governance committee meetings, but there were some items not regularly on the agenda. Items not regularly appearing on the relevant directorate agenda included, for example, the concerns and subsequent progress with the audit of the surgical safety checklist; the unimproved consent audit; surgical readmission rates, and a report of progress following non-compliance with many of the assessments of the National Emergency Laparotomy Audit 2014.
- Clinical governance meeting minutes for the directorates demonstrated there was discussion of incidents, complaints, good practice, resources, safety and risk. Updates from the divisions within the directorate fed into meetings, as did information from other parts of the governance structure, such as infection control and risk management. The quality of the minutes from the divisional meetings was variable.

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The managers of the directorates agreed there was not a set format for clinical governance meetings within their divisions to ensure consistency in what was discussed. Some minutes were good, but others did not record who attended, did not appear to have a set agenda, and there were no actions or review of previous actions or learning. Examples of this included the minutes of 21 April 2015 of what appeared to be the orthopaedic team, and those of the ophthalmology department from 23 January 2015. No names were provided, no record of who recorded the minutes, and there were no agreed actions or learning identified.

- There was commendable practice around bringing a 'sense-check' to directorate meetings. At the regular monthly specialty meetings, the regular attendees were able to bring a member of their staff team with them who would otherwise not attend. This member of the team was asked to listen to the meeting content, see if it made sense to them, and whether it described the service they worked in.
- The directorate divisional risk registers were being well used, although it recorded only risks and not action plans for resolving or reducing the risks identified. Risks rated as 'extreme' or 'high' were escalated to the trust risk register and allocated to a directorate or team to own, manage and reduce to an agreed level. The trust used SORT: the Salisbury Organisational Trigger Tool, to allow staff had a self-assessment risk tool to or teams to enable teams to review safety in their department or service. assess their own risks and escalate issues to the directorate manager. This process was carried out twice a year in preparation for mid-year or year-end reports, or more frequently if there were areas of concern to raise with the executive team or managers. and there was good contribution from both the medical and nursing teams.
- The directorates divided their responsibilities into separate forums for discussion. The directorates held monthly performance meetings with members of the executive team where items such as finance, human resources and risk management were discussed. There was some clinical governance discussed at these meetings, but this was in relation to performance and not high-level matters. There were 'stocktake' meetings held every quarter chaired by the trust chief executive. two months. These looked at the divisional issues and received reports on patient feedback, audit results,

National Institute of Health and Care Excellence (NICE) guidance and quality standard compliance, and reviews of incidents, complaints and compliments. Performance with waiting times and referrals were also presented. There was a comprehensive report for each directorate from human resources showing staff turnover, appraisal compliance, update training compliance, and staff absence levels.

- There was an excellent nursing documentation audit with an annual report produced. The audit reported on five sets of random notes collected from each of the surgery wards (other wards were also covered). They were examined by one of the nurse consultants. Actions from the audits were presented at the nursing, midwifery and allied healthcare professional forum. Four areas were assessed:
  - Nursing assessment on admission (29 standards).
  - Record keeping (7 standards).
  - Reassessment during admission (15 standards).
  - Care planning (9 standards).

There was an improvement in the first area, although a small deterioration since the 2014 audit in the other areas. Nevertheless, results were above 80%, but none actually met the targets of 95%.

- There were regular meetings between staff and teams of various roles, although not in all areas. Those taking place included, for example: theatre staff who met to discuss their risks and some aspects of performance; senior sisters meetings which were minuted under the CQC questions of safety, effectiveness, caring, responsiveness and leadership; and department leads and clinical nurse specialists who met and discussed actions from their previous meetings, appraisals and training compliance, staffing issues and quality performance. Staff on Britford ward said they had not had a ward meeting for over a year, although said there were other meetings, including safety briefings three times a day and handover meetings.

## Leadership of service

- There was committed leadership for the surgery directorates. Each directorate in surgery services had a clinical director who was a long-serving consultant; directorate managers; and directorate senior nurses. There were lead clinicians for each division sitting under the directorate, although some vacancies within the musculo-skeletal directorate. The senior staff we met

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were aware of areas of surgery services where improvements and innovations could be made, as well as where pressures and problems existed. Staff within the directorates and elsewhere spoke highly of the support from the senior managers. They said they were available for discussions, spent time in the departments, and recognised and tackled problems and challenges.

- There was strong and committed leadership at local ward and unit level. We were impressed with all the ward, team and unit managers. We met most of the senior sisters and charge nurses on the surgery wards and the theatre teams and managers. There was an extensive range of experience and commitment from the leadership staff with a focus on patient care and teamwork. Staff knew their patients well, and showed an empathy with those who had been in the hospital, as some burns and plastic surgery patients had been, for a long time.

## Culture within the service

- We found the staff to be committed to their patients and their wards or units. We were impressed with the positive culture within the staff we met. In conversations with staff, the things worrying them were all connected to patient care. These included delays to patient discharge, not being able to spend as much time with patients as they would like, feeling they had to rush patients out of the day-surgery unit, bed shortages, and safe staffing levels. However, despite a dedicated and caring workforce, the workloads from incorporating high use of agency staff and many new staff were causing staff stress and anxiety, which had not always been recognised. The majority of staff were otherwise positive about giving good care, support of the senior hospital staff, and supporting each other. This was expressed in the hospital by a long-serving workforce, good opportunities to develop new professional skills and qualifications, and a positive culture within the trainee doctors and nurses we met.
- Staff were told of compliments about their care and treatment. We saw thank-you cards on wards for staff to read. Many wards had boxes of chocolates and biscuits building into small mountains. These were being collected to share equally at Christmas among all the staff, including ancillary staff like cleaners and porters. We saw a high number of compliments including staff being singled-out by patients for their kindness and care. There were staff awards on a regular basis with

staff recommended by their peer group for achievements in small and big areas. In the Striving for Excellence awards for 2015, Chilmark Suite won for their customer care. They received a number of nominations that described them as “kind, supportive and helpful, with their professionalism standing out.”

- We recognised a good response to areas of staff concern. One of these was with the surgical assessment unit. This had been temporarily moved from its usual home on Britford ward, which was undergoing refurbishment, to Wilton ward in another part of the hospital. On one of the two days we visited we found the ward was under pressure and staff not able to cope well enough with the number of patients or lack of the usual support from Britford ward when it was next door. The following day we found a different and much improved atmosphere and the same on our unannounced visit. The ward beds had been reduced from 10 to eight. The side rooms had been decommissioned to make patients more visible. These were going to be used for patient examinations and any tests, and for staff to work. Staff told us they were not under pressure to take more patients than they could safely cope with. The site team were therefore aware when they were effectively full.
- Staff spoke highly about their managers. Specific comments were made to us about the team leader/sister in the pre-operative assessment clinic, the clinical director and lead nurse for surgery services, sisters in the Burns Centre and on Laverstock ward. Most without exception, staff on all wards and units said they were well supported by the senior executives, managers and team leaders.

## Public engagement

- Patients were able to give a wide range of feedback. There was monthly more detailed ‘real-time’ feedback from patient on the wards to supplement the Friends and Family Test. This was analysed and the comments were put into categories to look for any trends. Any more specific comments made by the patients were fed back to one of the members of the senior nursing team who commented upon how they had addressed any areas identified as concerns or negative feedback. In reviews from the musculo-skeletal wards in July 2015, as an example, it was noted however, the feedback from

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the sister was almost identical in each area. This was relating to wanting to check if there was further clarification available rather than recording any action taken following complaints.

- Patients took part in Patient-Led Assessments of the Care Environment (PLACE), although the results did not relate to named wards or the surgery services specifically. The results, which were mostly comparable to NHS averages, were encouraging for staff, patients and the trust.

## Staff engagement

- There was a lot of internal engagement with staff at both trust and local levels. There were weekly newsletters: a general one and one relating to 'health news'. The trust used an email broadcast facility to cascade messages through staff groups from the executive team and senior managers. There were newsletters produced by some wards and units. For example, Amesbury ward had produced a staff newsletter including complaint and compliment matters, reports from mealtime observations, and raising concerns.







- Staff were enabled to join as members of the trust and were represented within the governors. Six staff were appointed by election of the trust staff to the Council of Governors.

## Innovation, improvement and sustainability

- There was innovation and improvement sought and encouraged at Salisbury District Hospital. The hospital was the first in the Wessex region to carry out laser surgery for patients with enlarged prostates. This avoided the need for open surgery and enhanced recovery times. The hospital had a mobile monitoring machine for anti-coagulation testing. We heard how this was a great innovation for patients and staff as pin-prick tests could now be used rather than taking blood in the usual way. The equipment was being used in a one-stop clinic where patients were seen, scanned, assessed and treated without the need for admission. It was a developing service, but staff said it was going really well.



# Critical care

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

## Information about the service

Critical care services are located at Salisbury Hospital on the twelve-bedded unit called Radnor Ward. The unit was funded to provide care for nine patients in total comprising; five classified as needing intensive care (level three) and four requiring high dependency care (level two). Radnor Ward underwent significant refurbishment in 2014 increasing the number of physical beds from eight to twelve. Since the refurbishment, the unit had around 32 patient admissions per month (six months ending June 2015).

During this inspection, which took place between 1 and 4 December 2015, the inspection team spoke with 27 members of staff including consultants, trainee doctors, different grades of nurses, allied health professionals, critical care assistants and support staff. We also spoke with patients and their visiting relatives and friends. We checked the clinical environment, observed ward rounds, listened to nursing and medical staff handovers, and assessed patients' healthcare records.

## Summary of findings

Critical care services required improvement to be safe and well led. We found the service good for caring, effective and responsive.

Policies and procedures to prevent patients from the risk of healthcare associated infections were not consistently adhered to. The use of personal protective equipment was inconsistent by bedside nursing staff during the inspection. A commode was found to be dirty and a standard cleaning procedure for cleaning the commodes was not available on the unit.

There were occasions when nurse staffing numbers did not meet recommended staffing ratios. Medical staffing was found to be in line with core standards for intensive care services.

There was sufficient equipment to provide critical care and respond to emergencies. However, the resuscitation trolley log was not consistently signed to indicate that it had been checked and was ready for use. The bed spaces did not comply with best practice guidelines for critical care facilities regarding accessibility and space.

Incidents were reported and appropriate actions were taken to attempt to prevent recurrence. However, mortality and morbidity meetings had commenced recently and therefore could not provide assurance of any improvements or actions taken.

Overall, staff were aware of their responsibilities to report abuse and how to raise concerns about safety.

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Some online mandatory training rates for trained nurses were lower than the trust target of 85% and mandatory training compliance data for unit based staff was not supplied, which meant there was a risk that staff were not up-to-date with current practice.

Records and medicines were found to be stored and managed securely. However, documentation in the healthcare records and charts was not always complete or timely.

Patients' needs were comprehensively assessed and care and treatment regularly reviewed on the unit. Information about care and treatment and patients' outcomes was routinely collected and monitored. Local and national audits were taking place and results were being used to improve care, treatment and patients' outcomes. Staff could access the information they needed in order to deliver effective care. Patients care and treatment was planned and delivered in line with current evidence based guidance, particular focus was given to rehabilitation. However, we found that there were some guidance and policies on the unit that were out of date. In addition, documentation of patients' pain scores could be improved.

There was input into patients care from relevant members of the multidisciplinary team in order to provide effective treatment plans. However, the pharmacist did not attend consultant led ward rounds as recommended in the guidelines for the provision of intensive care services (GPICS 2015).

Staff were qualified and had the skills to carry out roles effectively in critical care. This included competencies in blood transfusion and intravenous therapy administration. However, half of the nursing staff had not received an appraisal in the last twelve months, order to identify learning needs. In addition, training in the use of equipment on the unit required further improvement for both medical and nursing staff.

Discharge from the unit was planned and included follow up services after going home from hospital, to support patients post critical illness.

Patients we spoke with were positive about the care they had received. Many kind and caring interactions were seen during the inspection. Staff were seen to maintain a high regard for patient's dignity and privacy.

Relatives expressed that they had been kept up to date with their loved ones progress and supported by the staff at the bedside. Not all relatives had received timely communication; one family had not been updated by medical staff. However, this was not a consistent finding amongst all relatives and visitors, and the majority were very happy with the level of emotional care and treatment they and their loved ones had received.

The support continued following discharge home from hospital via the follow up team that supported patients after critical illness. The follow up clinic that the team provided had recently held a reunion event which had been well attended.

Aspects of the refurbishment and design of the unit had been made in collaboration with staff and local people. The facilities for relatives had been improved with a thoughtful inclusion of secure storage of valuables in the waiting area. However, not all bed spaces were capable of giving reasonable auditory privacy. There were no toilet or shower facilities for patients within the unit. However, patients were able to access these facilities in a neighbouring ward without entering a general public area.

There were delayed patient discharges due to a bed elsewhere in the hospital not being available. Similar to most critical care units in England, in the last five years between 60% and 70% of all discharges were delayed by more than four hours from the patient being deemed ready to leave the unit.

Urgent surgical operations had been cancelled due to the lack of an available bed in critical care. This was above (worse than) the national average. Figures from NHS England reported 53 cancelled operations at the hospital between July and December 2015. We found that there was no limit per day for how many beds could be booked on the unit for those patients that require critical care after elective operations.

Despite the pressures on bed availability, patients were admitted to the unit in a timely fashion and the unit had not transferred patients to other units for non-clinical reasons for over twelve months. Data from the Intensive

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Care National Audit and Research Centre (ICNARC) showed that the unit transferred less patients to the wards out of hours than the England average (performed better).

Arrangements for governance of critical care services did not always operate effectively. For example, the risk register did not include risks that staff highlighted during the inspection and the risks had not been reviewed and updated. The governance structure and processes seemed immature and not embedded. In addition, it was not always clear how the local governance linked with formal trust wide processes. This meant that there was a risk that issues that required escalation were not being raised formally.

Following the refurbishment and recent changes in leadership of both nursing and consultant leads, the team appeared to be in a period of adjustment.

The team culture was strong within the unit. However, opportunities for staff engagement could be improved, for example unit meetings had been abandoned due to poor attendance.

## Are critical care services safe?

Requires improvement



Critical care services were found to require improvement regarding safety.

Policies and procedures to prevent patients from the risk of healthcare associated infection were not consistently adhered to. The use of personal protective equipment was inconsistent by bedside nursing staff during the inspection. One commode was found to be dirty and a standard cleaning procedure for cleaning the commodes was not available on the unit.

There were occasions when nurse staffing numbers did not meet recommended staffing ratios.

The resuscitation trolley log was not consistently signed to indicate that it had been checked and was ready for use.

The bed spaces did not comply with best practice guidelines for critical care facilities regarding accessibility and space.

Mortality and morbidity meetings had only commenced recently and action plans, where written, lacked detail. There was limited assurance of any improvements or actions taken.

Some online mandatory training rates for trained nurses were lower than the trust target of 85% and mandatory training compliance data for unit-based staff was not supplied, which meant there was a risk that staff were not up-to-date with current practice.

Documentation in the healthcare records and charts was not always complete or timely.

However:

Medical staffing was found to be in line with core standards for intensive care services.

There was sufficient equipment to provide critical care and respond to emergencies.

Incidents were reported and appropriate actions were taken to attempt to prevent recurrence.

Staff were aware of their responsibilities to report abuse and how to raise concerns about safety.

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Records and medicines were found to be stored and managed securely.

## Incidents

- An electronic incident reporting system was used to record incidents. Radnor Ward staff had reported 59 incidents between April 2015 and July 2015. The highest category was tissue viability, which included 14 reports of unit acquired pressure damage. The majority of these (13) related to medical devices such as airway tubes and were classed as superficial in nature. Evidence was seen that actions had been taken in response to these incidents, including for example, different airway tube tapes being used to reduce pressure.
- Staff we spoke with understood their responsibilities to report incidents or concerns. Staff felt able to raise concerns on the unit. They told us the main route they used were through incident reporting or discussions with the nurse allocated in charge of a shift.
- Most staff felt they received feedback from incidents. Staff told us that incidents were discussed, at safety briefings to raise awareness as part of the nurses' handover.
- Meetings had recently started to discuss patients' mortality and morbidity. Mortality and morbidity meetings did not follow a standard agenda and did not always include an action plan. An action plan that was developed lacked timescales and outcome measures. Medical and nursing staff attended them from Radnor Ward. However, we were informed that the first meeting had taken place in October 2015 and there had been two meetings so far. This meant that discussions of any improvements and learning related to mortality and morbidity had not been taking place formally until recently.
- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a new regulation which was introduced in November 2014. This Regulation requires the trust 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 with were generally aware of the new regulation to be open, transparent and candid with patients and relatives when things went wrong, and apologise to them. The minutes of a senior nurse meeting in August 2015 included discussions about how to demonstrate the Duty of Candour had been met. This

included indicating this on the electronic incident report and documenting conversations in the healthcare records. None of the incidents we viewed meet the thresholds required for further action in line with the regulations.

## Safety thermometer

- Data on patient harm was required to be reported each month to the NHS Health and Social Care Information Centre. This was nationally collected data providing a snapshot of patient harms on one specific day each month. It covered hospital-acquired (new) pressure ulcers (including stage two, three and four); patient falls with harm; urinary tract infections; and venous thromboembolisms.
- Safety thermometer data for Radnor Ward for the year January to December 2016 showed a harm-free care score of between 62.5% (April 2016) and 100% (August 2016). During this timeframe there had been four patients with new pressure damage, no patients with a new catheter-associated urinary tract infection, no falls with harm and one patient with a new venous thromboembolism (VTE). However, the trust informed us the VTE was a recording error and that in fact no patients had a new VTE during the period.

## Cleanliness, infection control and hygiene

- In March 2015, a patient acquired methicillin-susceptible *Staphylococcus aureus* (MSSA) bacteraemia (infection in the blood) on Radnor Ward. MSSA is a strain of bacteria that responds well to medicines used to treat *Staphylococcus* infections. An investigation report was completed and areas to improve included documentation of invasive device insertion and ongoing care. Also a central log was to be maintained for bed space damp dusting, which we noted to be in place. Data was reported by the unit to the Intensive Care National Audit and Research Centre (ICNARC: an organisation reporting on performance and outcomes for around 95% of intensive care units in England, Wales and Northern Ireland). This showed there was also a case of unit-acquired *Clostridium difficile* (a type of bacterial infection that can affect the digestive system) and a unit-acquired infection in blood between April 2015 and July 2015. However, ICNARC

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data for July 2015 to September 2015 showed that the unit was performing as expected regarding unit-acquired infections (compared to other similar services).

- At the time of our inspection, the overall environment and equipment in the unit were visibly clean and tidy. However, one of the commodes was found to be dirty. The critical care assistants (CCA) were responsible for daily cleaning of the commodes. Charts were found to be signed consistently to indicate that the commode cleaning had been carried out. Although it was acknowledged by staff that they did not have a standard way of cleaning the commodes and this did not always include taking the commode apart to clean. This issue was raised with senior nurses and the commodes were immediately cleaned. The Director of Infection Prevention and Control said standards for commode cleaning existed and these should have been available on Radnor Ward.
- Bed linen was in good condition, visibly clean and free from stains.
- Many items on the unit had been labelled to notify when they were last cleaned. There was a central cleaning and checking log that was used by critical care assistants and other members of the nursing team, to sign when items were cleaned and checked. This was consistently completed.
- There were alcohol hand gels and handwashing facilities available throughout the unit. However, there was not a hand wash basin for each bed space as recommended in Department of Health 2013 guidelines for critical care facilities (Health Building Note 04-02). There were 11 basins for 12 bed spaces. This was not documented on the unit's risk register.
- Overall, hand sanitising and personal protective equipment rules for staff were inconsistently followed on the unit. Most staff followed the policy by washing their hands between patient interactions and using anti-bacterial gel. Staff were bare below the elbow (had short sleeves or their sleeves rolled up above their elbow) when they were within the unit. The majority of staff wore disposable gloves and aprons at the bedside when working with a patient or, fluids or waste products. However, staff did not consistently employ best practice; for example, a nurse was observed to wear gloves to perform an airway suctioning procedure. The gloves were then not removed until after the nurse touched buttons on two different pieces of equipment in the bed space. Another nurse was seen emptying a urine catheter bag without wearing gloves or an apron. A senior nurse was informed of this practice and they recognised that compliance with this could be better. This was not documented on the unit's risk register.
- The local handwashing audit results showed compliance was between 85% and 100% in the six months ending August 2015. The results of another hand hygiene audit (included allied health professional as well as doctors and nurses) carried out in May 2015 showed a compliance rate of 67% with the five moments of hand hygiene. The World Health Organization stated the five key moments when hand hygiene should always take place for example, before touching a patient. It was also noted during this audit that all staff were 100% compliant with being bare below the elbow. Staff were also required to complete infection and prevention and control (IPC) training. Trained nursing staff had met the compliance target for this (85%). In addition, staff had to complete an annual practical hand hygiene assessment. However 34 out of 55 (62%) had not completed this update in the previous 12 months (as of December 2015).
- There were four side rooms available that could be used to isolate patients, if required, for infection control and prevention reasons. Three of these had lobbies as recommended in Department of Health 2013 guidelines for critical care facilities (Health Building Note 04-02).
- The equipment storeroom had a sign on it stating 'everything in this room is clean'. This was clarified with a senior nurse who agreed that this did not act as advice or a barrier to dirty equipment being put in the room and the poster was taken down.
- Bed space checklists were completed to indicate that it was cleaned, restocked and ready to be used. We found that a bed space had a checklist on it that belonged to another bed space and therefore could not offer assurance that the bed space was clean and ready. This was brought to a senior nurse's attention. The following day the nurse explained that there had been a patient admitted in an emergency to the bed space temporarily, which had caused the confusion with the checklist. Other checklists were checked during the inspection and were found to have been completed appropriately.
- There was a dishwasher in the kitchen but it had not been plumbed in due to problems with water pressure. This was not documented on the risk register.

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- All disposable equipment was in sealed bags and placed in drawers or cupboards where possible to prevent damage to packaging. Equipment in store cupboards was on racks to enable the floor area beneath to be cleaned.

## Environment and equipment

- There was secure access to the front door of the unit with swipe pass activation and cameras to allow staff to see who was trying to gain access. However, emergency exit doors were found to be unlocked, potentially giving access to theatres and equipment. This was raised with the clinical lead consultant who agreed that this was not ideal. Action was taken and the doors were secured when checked the following day.
- All checked equipment appeared to be well maintained, visibly clean and portable appliance tested. Storage rooms were generally tidy and kept free of clutter. There were two part time technicians based on the unit who also had responsibilities to theatres. Their role included maintaining service logs and ensuring that equipment was sent to be maintained as per manufacturers' specifications. They were also involved in training staff in how to use equipment.
- Radnor Ward had appropriate equipment for use in an emergency. All the patients' beds had emergency portable oxygen cylinders attached to them to be accessed, for example, in an evacuation. There were resuscitation medicines and equipment including a defibrillator. The resuscitation trolley containing the emergency equipment had closed drawers and was fully secured to prevent or indicate tampering with the contained medicines or other equipment between checks. However, logs were not always signed to indicate that it had been checked daily. The four months sheets were checked (July, August, September and November 2015) which showed there were between seven and 10 days a month where the trolley check had not occurred. This meant there was a risk that resuscitation equipment would not be available in an emergency. There was also a difficult airway trolley available stored in the theatre department, which was adjacent to Radnor Ward.
- The equipment around the bed spaces was located on ceiling-mounted pendants for optimal safety. There were also two ceiling hoists and a mobile hoist available

to assist with patient manual handling. There were sufficient oxygen, four-bar air, and vacuum outlets (as recommended in Department of Health 2013 guidelines for critical care facilities, Health Building Note 04-02).

- There was a good level of mobile equipment available including haemodialysis/ haemofiltration machines, an electrocardiography machine, defibrillator, cardiac output monitoring, non-invasive respiratory equipment and portable ventilators.
- There was a range of disposable equipment available in order to avoid the need to sterilise equipment and significantly reduce the risk of cross-contamination. We saw staff using and disposing of single-use equipment safely at all times.
- Department of Health guidelines for critical care facilities (Health Building Notes) gave best practice guidance on the design and planning of new healthcare buildings and on the adaptation or extension of existing facilities. We were informed that following the refurbishment of Radnor Ward none of the bed spaces met the size specifications as recommended in Health Building Note 04-02. We found that two corner bed spaces were restrictive. These did not provide:
  - an unobstructed circulation space at the foot of each bed space to maintain the required bed separation for infection control reasons and aid positioning of equipment
  - space to allow staff to manoeuvre the patient, themselves and equipment safely due to the close proximity of neighbouring bed spaces
  - space to allow five members of staff to attend to the patient in an emergency situation
  - space to accommodate the specialised beds that were used for the other critical care patients.

A consultant explained that the two bed spaces in question were adequate, especially for level one and two patients. However, during the inspection an intensive care (level three) patient was admitted into one of the bed spaces. The operational policy that was in draft for Radnor Ward did not include any restrictions in use for any of the bed spaces. A critical care steering group was established during the planning stages of the project, which included senior medical and nursing staff from Radnor Ward. The group were asked to consider the proposed layout of the unit including the bed spaces not meeting size specifications as recommended in Health Building Note 04-02. They concluded that this was acceptable if ceiling



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pendants were installed for equipment (in place at all bed spaces at the time of inspection) and areas used as escalation only 'as part of a phased expanded approach'. Initially the unit was to provide care for 10 patients. A risk register was also developed for the refurbishment. Insufficient space to meet current bed space recommendations was included and stated that 12 beds could be used during periods of escalation if risk assessments were undertaken to reduce risks to patients. However the issue of risk assessments was not included in the draft operational policy; neither was there a documented risk assessment for a patient cared for in one of these beds during the inspection.

## Medicines

- Medicines and intravenous fluids were stored appropriately. Medicines were stored in cupboards with staff only swipe access.
- Medicines required to be refrigerated were kept at the correct temperature, and so would be fit for use. We checked the refrigeration temperature checklists, which were signed to show the temperature had been checked each day and these were within the correct range, as required. There was also a temperature range decision tree, to guide staff when to take action. The thermometer also captured the maximum and minimum temperatures that the fridge had reached in the previous 24 hours. On occasion, this had been just above the maximum temperature range and the nurse in charge had been informed accordingly.
- Controlled drugs (CDs) were managed in line with legislation and NHS regulations. The medicines, in terms of their booking into stock, administration to a patient, and any destruction, were recorded clearly in the controlled drug register. Stocks were accurate against the records in all those we checked at random.
- Bedside nurses were seen to check all medicine infusions were running as prescribed as part of their safety checks at the start of each shift.
- A 'safe and secure' medicines audit carried out in August 2015, highlighted the need to ensure daily checking of fridge temperatures and secure resuscitation trolley. These items were found to be satisfactory during the inspection.
- We found a patient with a known severe reaction allergy was not wearing a band to indicate this to staff. The allergy was documented in healthcare records and on the prescription chart. When an inspector brought this

to the bedside nurse's attention, they explained that because the source of the allergy was a wasp sting and not a medicine, the band was not required. Following discussion with the nurse in charge of the unit, an allergy band was put in place. The trust policy for the safe management of patients with allergy was provided. This was under evaluation as it was past the review date of December 2014. The policy stated that all patients with a known allergy must wear red wristbands. This was not reported as an incident initially but was following the inspector's recommendation. Following the incident, an e-mail was sent to whole senior team to remind them that all allergies with a significant reaction needed to be recorded in the patients' healthcare records, on the prescription chart, and a red band should be worn. Seven prescription charts that were reviewed during the inspection, all had the patients' allergy status documented appropriately.

- Evidence of antibiotic stewardship was seen during the inspection and five antibiotic prescriptions checked were in line with the trusts antibiotic policy.

## Records

- The observation charts included the patient's vital signs, fluid balance chart, position changes for patient, ventilator observations and record of specimens sent. All six observational charts we reviewed were completed as required and timed, dated, legible and clear. Chart covers were used for the observation charts to maintain confidentiality.
- The patient's healthcare records were stored securely in paper-based files. Custom designed bedside trolleys incorporated drawers for healthcare records, which trained staff could access via swipe pass. This helped with maintaining confidentiality.
- The documentation was noted to be contemporaneous, maintained logically and filed appropriately. Entries were signed and dated, however the author did not always print their name as stated in generic medical record keeping standards (2015).
- Overall, records could have been more complete. A patient's healthcare record was checked that had been on the unit for two days. We found that the reverse of the admission chart, which should contain information regarding social history, family tree, passwords and authorised visitors, was blank. The communication record where discussions with the patient or relatives would be documented was also blank. The reverse of

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the observation chart that contained assessment and management plans was not always completed. A patient's record that we checked during the afternoon did not have this completed despite ward rounds having taken place in the morning. This meant that the staff might not have had access to the current treatment decisions. This was in line with results of nursing documentation audit carried out in April 2015 which showed non-compliance (target 95%) in the following areas:

- nursing assessment on admission (61%)
- record keeping (57%)
- re-assessment (84%)
- care planning (67%)
- We saw completed nurses' documentation, for example for bedrail management, malnutrition screening, falls risk, patient manual handling assessment, wound and communication charts. Records demonstrated personalised care and multidisciplinary input into the care and treatment provided. However, some of the charts that were used such as the bed rails assessment and the admission record were printed or photocopied locally. Handwritten prompts were seen for patients name and hospital number were noted on the bed rails assessment. Review dates for version control of the documents used were not always present. This meant there was a risk that staff were not using the most up-to-date versions of charts.
- At a recent critical care governance meeting (November 2015) it was discussed that a recent audit had highlighted documentation of ward round plans in the medical notes required improvement. Following this, the Radnor medical staff implemented a sticker mini checklist. We saw this used each day, following the ward round. This sticker included a date and consultant name prompt and finished with a reminder to lock notes away. The seven records that we checked had generally a good standard of record keeping by the medical staff. The trust audited record keeping standards annually. However, no audit to monitor local progress had been planned. Consultants were seen to document their own reviews during ward rounds on the unit.
- Physiotherapists completed separate assessment forms every day for patients who were ventilated. These forms were yellow which meant they were easy to locate within the healthcare records.

## Safeguarding

- Overall, staff were aware of their responsibilities to report abuse and how to find any information they needed to make a referral. We spoke with a range of doctors and nurses who were able to describe those things they would see or hear to prompt them to consider there being some abuse of the patient or another vulnerable person. Most were aware of the teams within the hospital to contact, and that the information could be found on the trust intranet. There were also two staff that were named safeguarding champions for the unit.
- Staff were trained to recognise and appropriately respond in order to safeguard a vulnerable patient, and had updated their mandatory training by the trust deadline. Safeguarding training was mandatory and covered vulnerable adults and children. Data supplied by the trust showed that 96% of trained nurses had completed safeguarding adults training and 85% had completed the safeguarding children training (November 2015).
- A safety brief was incorporated into the nurse handover. This included whether any of the patients were classed as vulnerable adults. A patient on the unit was highlighted as a vulnerable adult during the inspection. Following the patients admission, the situation had been discussed with the trusts adult safeguarding lead for advice. An adult safeguarding referral to the local authority was deemed unnecessary and all appropriate actions appeared to have been taken.

## Mandatory training

- Radnor Ward devised and ran their own mandatory training study day to ensure that staff had training specific to critical care. This included basic life support, fire evacuation, manual handling and epidural updates. Study days were allocated on the off duty to enable staff to attend.
- Some mandatory training that staff were required to maintain was accessed online. These included equality and diversity, infection control and moving and handling.
- Radnor Ward trained nurses were compliant (85% or more) with online mandatory training in safeguarding adults and children and infection control and prevention. They were not compliant with:
  - equality and diversity (78%)
  - moving and handling (75%)
  - fire safety (58%)

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- information governance (55%)
- hand hygiene assessment (38%)

Information about compliance with mandatory training for all staff groups and subjects for Radnor Ward specifically had been requested but not provided by the trust.

## Assessing and responding to patient risk

- The nursing team and medical staff assessed and responded well to patient risk through regular reviews. Consultant led ward rounds in the unit took place twice daily in the morning and evening. This met core standards for critical care units. There was input to the ward rounds from unit-based staff including the doctors and the nurses caring for the patient.
- The nurses handover at the beginning of each shift included a safety brief which included patients at risk of developing pressure ulcers and those not for attempted cardio pulmonary resuscitation. Patients were closely monitored so staff could respond to any deterioration. During the site visit patients were nursed by recommended levels of nursing staff at all times. Patients who were classified as needing intensive care (level three) were nursed by one nurse for each patient. Patients who needed high dependency care (level two) were nursed by one nurse for two patients. However, a number of nurses informed us that sometimes these ratios were not maintained due to staffing levels. The electronic reporting system was used to highlight shifts that were short staffed. There were 16 flagged short staffed shifts between August 2015 and November 2015.
- There was a standardised approach for detection of the deteriorating patient. There was an early warning scoring tool that was incorporated in to the ward patients' observation chart. If a ward-based patient triggered a high-risk score from one of a combination of indicators, staff would follow a number of appropriate routes. One of the triggers would include a review of the patient by the critical care outreach team (CCOT). This team consisted of mainly experienced critical care nurses. It had been established to support all aspects of the adult critically ill patient, including early identification of patient deterioration. The CCOT and the patient's medical team were able to refer the patient directly to the consultant for support, advice and review. The CCOT provided 24-hour cover for the hospital as recommended in the guidelines for the provision of intensive care services 2015.

- CCOT provided advice to patients that had non-invasive ventilation and tracheostomies throughout the hospital. Specific risk assessment charts had been developed by the CCOT, to support staff outside of the unit with patients that required these interventions.
- The CCOT also provided training to ward nurses through a planned annual programme. The subjects covered included sepsis, care of the breathless patient and acute illness management (AIM). The AIM study day incorporated competencies and tests, which provided evidence of learning.
- There was a consultant nurse for critical care employed by the trust. The role was mainly regarding the care of critically ill or those at risk of deteriorating outside of Radnor Ward. Professionally they were involved with the critical care outreach team (CCOT) and clinically worked with this team twice a week. They were involved in improvement projects throughout the trust, including the electronic observations pilot and surviving sepsis.

## Nursing staffing

- The actual and planned staffing levels for each shift were seen on display at the entrance to the unit.
- Trained nurses worked a 12.5 hour shift pattern and rotated on to night duty.
- There was always a senior nurse for each shift for both day and nights, which would ensure there was experienced support and advise for the staff.
- The rotas were generated and managed via an electronic system. Eight trained nurses were required per shift as a minimum. The rotas were checked during the inspection and we found that they did not always have the minimum number of nurses. For example, we checked nine days at random and compared how the numbers of staff met the level of care required for the patients present on the unit at that time. We found that out of nine shifts, five did not have the required numbers of trained staff. The details of these occasions were not documented. However, the electronic reporting system was used to highlight shifts that were short staffed. There were 16 flagged short staffed shifts between August 2015 and November 2015. Based on eight nurses per shift and allowance for annual leave study days and sickness 43.73 whole time equivalent (WTE) was required. The actual WTE was 40.28. Also, there was a secondment and staff on maternity leave that were not covered and two staff on long-term sick

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leave. There had also been a recent turnover of staff and 13 band five nurses had been recruited in the last six months. We were told there were plans to go to the trust board to increase the nursing establishment.

- There was a staffing escalation policy for Radnor Ward, which guided what actions to take if there were not enough nurses. This started with checking if unit staff could swap shifts or work extra and escalated to the uncovered shift request going out to agency. The report to the trust board (August 2015) reviewing nurse staffing included that the layout of the new unit meant that when the side rooms were all in use there was an extra 'runner' required overnight. . Data supplied by the trust indicated 1.4% to 0.3% of agency nursing staff were employed per month. This included specialist agency staff for critical care. A member of the management team had to agree to request agency staff from certain agencies due to the expense. We were informed that the trust would prefer to employ agency staff than to close beds to admissions. During the inspection, we also noted staff that had been allocated management time were caring for patients on the unit. The trust informed us that although this was not ideal in the long run, this was part of the escalation to maintain nurse to patient ratios during busy periods.
- An agency nurse told us they had received an orientation induction at the start of their shift on the unit. This was because even though she had worked on the unit before, it had undergone a significant refurbishment since then. Agency staff induction checklists were seen being completed and they included the layout, emergency bleeps, fire procedure, and resuscitation equipment. Five forms were checked and they were all filled in fully and signed by the agency nurse and the Radnor Ward nurse. Another agency nurse was observed coming on duty and was greeted by the nurse in charge. They went through the orientation process and gave the agency nurse a swipe access pass to enable them to access medicines. Staff sent feedback to the agency if nurses had not worked well on the unit or if there were concerns about their practice. This was seen being done during the inspection.
- Critical care assistants (CCA) were employed by the unit. They were equivalent to care support workers but the role had been specifically adapted to the needs of a critical care unit. Their role included; competency

supported skills such as putting arterial blood gas samples through the bedside analyser, supervision of confused patients and assisting with meals. They also attended to the daily cleaning schedule for the unit.

- There was a good handover among nurses. Initially a brief handover of all the patients to all of the shift staff occurred, highlighting the patient's name, diagnosis and support required. This followed a structured style based on the nurse in charge's handover sheet. All the oncoming team including the critical care technician, physiotherapist and the CCOT nurse attended it. The oncoming nurse in charge allocated nurses to patients to care for, dependant on previous day's allocation, skill-mix, and developmental needs of staff. Then nurses had a more detailed handover at the bedside for the patient /s they had been allocated. The nurse in charge handed over to the oncoming nurse in charge. The chart they were using captured basics regarding the patient admitted and cared for on the unit for a 24-hour period. These were then kept for retrospective review.

## Medical staffing

- The level of cover provided by medical staffing on the unit met all professional standards and recommendations.
  - There was a good consultant to patient ratio because there was one consultant on duty or on call for an absolute maximum of twelve beds. This was better than the core standards recommended ratio of one consultant for a maximum of 15 beds.
  - Consultants provided a good level of continuity. A consultant would spend three or four full days working on the unit.
  - The use of locum junior medical staff was rare (20 occasions in the six-month period ending November 2015) and there was an induction pack developed, to be used for any locum doctor that was employed.
  - There was always an anaesthetist that specialises in intensive care covering the unit. All seven consultants were fellows of the faculty of intensive care.
  - Staff told us and we saw evidence in patients' health records that a consultant conducted a ward round each day including at the weekend. However, this did not meet the core standard for intensive care units, which states that consultants must undertake at least twice daily ward rounds including weekends and bank holidays.

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- When consultant intensivists were on call, this was for critical care only. The core standard states that a consultant in intensive care medicine must be immediately available 24 hours a day, seven days a week. Staff from a variety of disciplines told us and we saw evidence that the consultant was available out of hours.
- Out of hours cover for the unit was by a registrar who also provided cover for maternity, critical care referrals for the hospital including ED, and was sometimes required to support a more junior trainee in theatres. The junior doctor included twilight shift (5-8pm) covered by a registrar with other roles. When the unit was busy during this out-of-hours period, the consultant would often attend to help. A trainee doctor confirmed that they felt supported and the consultant was available. However, data provided by the trust showed that in the three months ending June 2015, nine beds were occupied 15% of the time and on occasion the unit had 11 beds in use. This meant that the standard of one doctor to eight critical care patients for the junior critical care doctor would have been exceeded.
- Despite the medical staffing meeting core standards, the way in which the consultant rota was structured meant that the consultant for the unit was to be available for three or four days in a row. This included the night cover. On two occasions, we found the consultant had been stood down to allow rest due to particularly busy night shifts. This was managed well by calling other consultants in and safe cover was maintained at all times. A consultant told us that with such a cohesive team there had never been an issue covering each other. There was no formal agreement to cover busy periods such as, a second on call consultant on the rota. The trust acknowledged that although the consultant rota worked well and provided continuity of care it may become necessary to review this if the unit becomes busier in the future.

## Major incident awareness and training

- It was noted during an internal patient-led assessments of the care environment (PLACE) assessment in January 2015 that the emergency exits were classed as not being free of obstruction due to items storage. One of the corridors that had emergency exit doors was also found to be cluttered on the first day of the inspection. The

doors themselves were clear. However, equipment would have needed to be moved from the corridor to enable patient on beds to be evacuated easily. This was brought to the immediate attention of the senior nurse and the area was found to be clear the following day.

- There was a fire risk assessment for Radnor Ward and a fire emergency plan held locally on the unit. Exit signs and emergency alarms were clearly visible. However, 58% of trained staff had completed their fire safety training via electronic learning. Practical fire safety was also covered during in-house mandatory training days. Information about compliance with this had not been provided by the trust.
- There was a major incident policy for the trust, which was under review. There were action cards for the consultant on call and the nurse in charge of the unit. These summarised actions to be taken including assessment for stepdown of patients from the unit and arranging a satellite critical care unit in theatre recovery.
- Business continuity plans were supplied by the trust detailing actions to be taken by Radnor staff in the event of fire, flood or loss of power.

## Are critical care services effective?

Good



We found critical care services overall to be providing effective care with some areas requiring improvement.

Patients' needs were comprehensively assessed and care and treatment regularly reviewed on the unit. Information about care and treatment and patients outcomes was routinely collected and monitored. Local and national audits were taking place and results were being used to improve care, treatment and patients' outcomes. Staff could access the information they needed in order to deliver effective care. Patients care and treatment was planned and delivered in line with current evidence based guidance, particular focus was given to rehabilitation. However, we found that there were some guidance and policies on the unit that were out of date. In addition, documentation of patients' pain scores could be improved.

There was input into patients care from relevant members of the multidisciplinary team in order to provide effective



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treatment plans. However, the pharmacist did not attend consultant led ward rounds as recommended in the guidelines for the provision of intensive care services (GPICS 2015).

Staff were qualified and had the skills to carry out roles effectively in critical care. This included competencies in blood transfusion and intravenous therapy administration. However, half of the nursing staff had not received an appraisal in the last twelve months, order to identify learning needs. Although the unit had a comprehensive training programme, training in the use of equipment on the unit required further improvement for both medical and nursing staff.

Discharge from the unit was planned and included follow up services after going home from hospital, to support patients post critical illness.

Consent to care and treatment was obtained in line with Mental Capacity Act 2005.

## Evidence-based care and treatment

- Patients' care and treatment was assessed during their stay and delivered along national and best-practice guidelines. For example, National Institute of Health and Care Excellence (NICE) 83: Rehabilitation after a critical illness, and NICE 50: Acutely ill patients in hospital. Rehabilitation needs of critical care patients were clearly a priority. This included:
  - Using target charts on display in every bed space to plot where a patient is on a day to day basis related to eight personal care basics (for example able to brush hair)
  - Mobility staircase prompt poster was on display in every bed space to plot where a patient is on a day-to-day basis.
  - A therapy assistant was employed on a trial basis for the unit. This was to dedicate time to patients with rehabilitation needs.
  - Effectiveness of rehabilitation monthly audits were being completed. These showed (May 2015 to October 2015) 100% compliance with assessing patients within 24 hours of admission and 90% of the time patients had rehabilitation plans in place at discharge.
- Patients' length of stay was submitted to the Intensive Care National Audit and Research Centre (ICNARC: an organisation reporting on performance and outcomes for intensive care patients). The mean average length of stay for all admissions in the unit was between eight and 10 days for the 12 month period ending June 2015 which was comparable with the national average.
- Patient care was audited regularly against best practice standards (care bundles) in the following key areas related to critical care and compliance rates for January 2015 to September 2015 included:
  - central line (venous access devices) insertion and care (90-100%)
  - care of ventilated patients (100%)
  - peripheral (access devices) line insertion and care (50-100%)
  - venous thromboembolism (VTE) prevention (100%)
- Patients were ventilated using recognised specialist equipment and techniques. This included mechanical invasive ventilation to assist or replace the patient's spontaneous breathing using endotracheal tubes (through the mouth or nose into the trachea) or tracheostomies (through the windpipe in the trachea). The unit also used non-invasive ventilation to help patients with their breathing using usually masks or similar devices. Ventilated patients were constantly reviewed and checks made and recorded hourly.
- Radnor Ward followed NHS guidance when monitoring sedated patients, by using the Richmond Agitation Sedation Scale (RASS) scoring tool. This involved the assessment of the patient for different responses, such as alertness (scored as zero) and then behaviours either side of that from levels of agitation (positive scoring) to levels of sedation (negative scoring). Audits were also carried out by the unit regarding diagnosing, preventing and treating delirium in critical care.
- Patients were assessed for risks of developing venous thromboembolism (VTE) such as, deep vein thrombosis from spending long periods immobile. There was a daily review of patients for risks of developing VTE and patients were provided with preventative care including compression stockings and sequential compressions devices in line with NICE83 statement 5. The key quality indicators for Radnor Ward showed that this assessment was carried out 100% of the time (January to September 2015).
- Radnor Ward met best practice guidance by promoting and participating in a programme of organ donation, led nationally by NHS Blood and Transplant. As is best practice, the critical care unit led on organ-donation work for the trust. There was a specialist nurse for organ



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donation who was employed by NHS Blood and Transplant and was based at the hospital, to directly support the organ donation programme and work alongside the clinical lead. The specialist nurse also supported a regional and community programme for promoting organ donation, which was supported by the trust organ donation committee. The specialist nurse submitted data to the national audit regarding potential organ donors. We reviewed data about donations from Salisbury District Hospital for the year from 1 April 2014 to 31 March 2015 and the most recent six-month report from April to September 2015. There had been 17 patients eligible for organ donation during this 18-month period. Of these, there was an approach to six families to discuss donation. The specialist nurse was involved with five of these families (83%), against a national average of 73% involvement. Evidence has shown there is a higher success rate for organ donation if a specialist nurse is involved with discussions with the family. In the 18-month period, three patients went on to be organ donors and six people became recipients of those organs.

- The team were meeting core standards relating to engaging, and participating in a critical care operational delivery network. Senior medical and nursing staff were seen to have attended quarterly meetings.
- There was a local ongoing audit plan in evidence to evaluate policies or effectiveness of treatment interventions. For example, a baseline audit had been recently completed assessing both patients opinion and staff perception of good sleep. This was in preparation for a planned launch in December 2015 of a new 'sleep care bundle' (best practice care plan). A patient told us they had experienced difficulty sleeping on the unit, due to the alarms and bells waking them up. Nurses also informed us that patients who were sedated and ventilated, would routinely be washed between 6 and 7am. This meant patients' sleep may have been disturbed by this practice.
- A daily checklist sticker was being used to support effective ward rounds. This was placed in the healthcare records after the review of the patient and included reminders including bowel management, blood tests, and VTE prevention.
- We found guidance and policies that were available on the unit, including bedside reference guides were out of date. For example, the insulin protocol was dated 2005. This was highlighted to a senior nurse who informed us

staff usually accessed a computer for the latest policies. However, they acknowledged that they was a risk that staff may access information that was not up to date and would ensure that this was addressed.

- It was decided following a ward round review that a patient required nursing in a 'prone position'. The policy regarding this procedure was provided. This was within date and explained that current evidence suggested that early turning of patients onto their fronts improved chances of survival in acute respiratory distress syndrome.

## Pain relief

- Staff carried out assessments of the severity of a patient's pain and it was given a score. Pain scores were logged on the observation chart and the management plans embedded on the reverse of this chart included a question about whether the patient's pain was controlled. However, we found that this documentation of patient's pain scores could be improved. We checked seven patients' current observation charts for presence of pain scores and five out of seven had been completed. In addition, a patient that we spoke with said that they had experienced pain occasionally. We found that there were no pain scores documented on their observation chart.

## Nutrition and hydration

- Patient nutrition and hydration needs were assessed and effectively responded to. Nutritional planning was considered daily and supported by documentation including a section of the daily assessment sheets. Fluid intake and output was measured hourly, recorded and analysed for the appropriate balance and any adjustments necessary were recorded and delivered. The method of nutritional intake was recorded and evaluated each day. Any feeding through tubes or intravenous lines was evaluated, prescribed and recorded.
- The unit had guidance and support for specialist feeding plans. A dietitian attended the unit every weekday to provide advice. There was also a nutrition support team who supported parenteral feeding such, total parenteral nutrition (nutrients supplied intravenously through a central venous access devices). There were approved protocols for nursing staff to commence enteral feeding, including clear flowcharts.

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- Meals for specific dietary requirements were available on request including gluten free, low allergen, soft diet and for religious needs.
- Patients on Radnor Ward who were able to eat and drink, were given choices every day regarding what they would like for their meals and assistance provided as necessary, to enable the food to be eaten. A patient told us that the food was excellent.
- A patient who was waiting to be transferred to a ward bed was seen to have access to water to drink, placed within reach.
- At the time of the inspection, 94% of trained nursing staff were deemed competent to administer intravenous fluids and medicines. Newly qualified staff could begin to obtain their training and competencies to administer intravenous (IV) fluids after three months (trust standard). An algorithm was used to determine if newly employed staff needed to undergo further IV training. However, following the initial IV training there was no requirement by the trust for any updates regarding intravenous administration. This did not meet NICE guidelines that stated that hospital should establish systems that reassess staff at regular intervals to demonstrate competence (NICE guidelines CG174). This meant that there was a risk that staff may not be up to date with best practice.

## Patient outcomes

- Around 95% of adult, general critical care units in England, Wales and Northern Ireland participate in ICNARC the national clinical audit for adult critical care; the case mix programme (CMP). Following rigorous data validation, all participating units received regular, quarterly comparative reports for local performance management and quality improvement. There was an administration assistant employed by the unit whose role included the input of data for ICNARC.
- The unit was performing as expected (compared to other similar services) in all CMP indicators used in the ICNARC Annual Quality Report (2013/2014) and these areas were:
  - Hospital mortality
  - Out of hours discharges to the ward
  - Non clinical transfers (out)
  - Unit acquired MRSA
  - Unit acquired infection in the blood
  - Delayed discharges
  - Unplanned readmission within 48 hours

## Competent staff

- Staff were required to be assessed each year for their competency, skills and development. All staff knew who was responsible for their appraisal and staff in lead roles knew who was in their team and due an appraisal. The nurses were divided into teams each led by a senior nurse to facilitate team working and organise appraisal completion. However, we were informed that 50% of the nursing staff had been given an annual review of their competence and performance. One reason that was offered to explain the low nurse appraisal rate was lack of management time, due to the busy nature of the unit.
- There was good support to trainee doctors. A trainee doctor explained that they received a local departmental induction and good supervision in role on the unit. They had an educational supervisor and regular meetings. They enjoyed working on the unit and would recommend the placement to colleagues. We were informed that medical staff appraisal rates and revalidation was 100%.
- An experienced critical care nurse was employed in an education role for the nursing staff. This was in line with core standards, which stated that each unit was to have a dedicated clinical nurse educator responsible for coordinating the education, training framework for nursing staff and pre-registration student allocation. They were also involved in delivering lectures on the post registration critical care course and the course design. The role was not included in the number of staff allocated to care for patients. However, the clinical educator was allocated patients occasionally to ensure safe staffing levels. Although not ideal, it did provide an opportunity to educate staff during the shift and demonstrated a flexible approach to maintaining patient safety.
- Each month the clinical educator submitted the status of trained nurse competency and training regarding blood transfusions. The training rates for June 2015 show that rates were between 86% and 97% (for the four competencies).
- Two trained nurses were funded to attend the post registration critical care course each year. There had been a training needs analysis and which recommended this number to increase to three nurses a

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year in the future. 62% of trained staff held a post registration award in critical care, which exceeded the minimum set by core standards for critical care services (50%).

- We were told, and we saw evidence, that new nursing staff to the unit had a period of time where they were supernumerary (extra to the clinical numbers) in line with core standards. Generally, it was four weeks. However, this was also the case for three newly qualified nurses who joined the team recently. This did not meet core standards of a minimum of six weeks supernumerary time for newly qualified staff. Two of the recent starters (including one newly qualified nurse) had been given further supernumerary time after support and training needs were identified by their mentors and the practice education team. These staff had individually assigned short-term objectives set with regular scheduled reviews and were supervised and supported by key members of the team.
- Clear induction processes were available for new nursing staff supported by documentation, which we saw during the inspection. This included a checklist that was completed in this period. Critical care worksheets and competencies were also used for key skills including; tracheostomy care, arterial lines and venepuncture. We observed informal bedside teaching taking place between nurses at the bedside.
- The newly qualified staff were included in the trusts preceptorship programme, which supported their first year as a qualified nurse. This ran alongside the local induction to Radnor Ward.
- Nurses completed a medicines administration competency when they first started working at the trust, but no updates were required. This meant there was a risk that staff were not kept up to date with best practice.
- Training in the use of equipment required improvement. There had been a recent focus to improve this for nursing staff, as gaps in training had been identified. The clinical educator had arranged specific study days for the nurses covering key equipment, which started November 2015, and further dates were planned. A spreadsheet was also being maintained electronically so that compliance could be reviewed. However, we were told that equipment training for medical staff was

provided but not captured formally. As primary responsibility for use of the equipment rests with nursing and technical staff, medical staff do not operate unfamiliar equipment without supervision.

## Multidisciplinary working

- The unit had input into patient care and treatment from the physiotherapists, dietitians, microbiologist (a healthcare scientist concerned with the detection, isolation and identification of microorganisms that cause infections) and other specialist consultants and teams as required. We witnessed members of the multidisciplinary team (MDT) contributing to patients care and treatment. For example, a physiotherapist told us they felt integral to the team on Radnor Ward. All the members of the MDT did not routinely attend the ward rounds on the unit. However, the nurse in charge of the unit did and would collate advice and help to communicate effectively plans made by other disciplines.
- Discharge from the unit was supported by documents that were jointly completed by medical and nursing staff. This included rehabilitation information, infection control issues, psychological and emotional needs and checklist of prompts and reminders. This was to provide ward staff with relevant at a glance information in order to care for the patient.
- The critical care outreach team (CCOT) reviewed patients discharged from the unit. Patients would then be visited once they had settled into the new ward. There was no limit to the reviews and these would be done as often or as little as required.

## Seven-day services

- The CCOT provided a 24-hour, seven day a week service covering the whole trust. Out of hours they worked alongside the hospital at night practitioner.
- Occupational therapist input and advice could be obtained if required. However, staff felt that this support could be increased.
- The pharmacist was not dedicated to Radnor Ward, however they did attend the unit every day Monday to Friday and this provision met the recommended level. The pharmacist did not attend consultant-led ward rounds as recommended by the core standards for critical care units (GPICS 2015).
- Physiotherapists covered the unit every weekday morning and reviewed all new patients for rehabilitation

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needs and planning. They attended a safety round on the unit to receive handover with the nurse in charge and lead consultant each weekday morning. Physiotherapists were available at the weekends and overnight, via an on call system. Frequent physiotherapy reviews were seen documented in health care records; including daily reviews of patients at the weekend.

- Staff told us that at the weekend, the consultant attended the unit and was available. We saw evidence in-patient records of consultant led ward rounds being documented. Medical and nursing staff maintained that the unit was consultant led and they were available out of hours, were easy to reach, and would come in if required.
- The dietitian provision was not a dedicated service for critical care, but available Monday to Friday. The trust informed us that dietetic services were delivered from their community provider according to a service level agreement. In practice, there was five to six hours of senior cover per week for the unit. The service met the core standards for critical care(GPICS 2015).
- Speech and language therapists were available on request, Monday to Friday.

## Access to information

- Staff had access to relevant information to assist them to provide effective care to patients during their stay. All substantive staff had access to email accounts. Healthcare records at the trust were paper based and were available at the patient's bedside. Some information including results from patient investigations and guidance was available via the trusts intranet. For example, during the consultant-led ward round, a portable computer on wheels accompanied the staff. This allowed patients diagnostic results to be accessed, as well as guidance and policies. Although, staff told us that the search engine for finding policies was not always successful. This was not a consistent complaint from staff we spoke with.
- We met a ward clerk on the unit who was based at the workstation. This role clearly supported effective communication with visitors and staff throughout the unit.
- The trust intranet was open and available to all substantive staff. The staff had good levels of access to

their own information. We were told that all nursing staff had a general password to access information on the computer and all had access to a shared drive to access documentation and information.

## Consent and Mental Capacity Act

- Patients gave their consent when they were mentally and physically able. The staff demonstrated a good awareness of the Mental Capacity Act 2005. A doctor working on the unit told us that patient's mental capacity was regularly discussed on the ward round.
- Senior staff admitted that initially following the Supreme Court judgement they had been over-reporting and had been requesting Deprivation of Liberty Safeguards (DoLS) authorisation on all patients that were sedated and ventilated on the unit. There had been clarification received via the lead for the trust and the policy updated to support that this was not always required and should be on an individual case basis. A log of patients that required DoLS consideration was maintained at the unit's workstation. There were not any DoLS authorisations in place at the time of the inspection.

## Are critical care services caring?

Good



Critical care services were providing good, compassionate care.

Patients were positive about the care they had received. Many kind and caring interactions were seen during the inspection. Staff were seen to maintain a high regard for patient's dignity and privacy.

Relatives expressed that they had been kept up to date with their loved ones progress and supported by the staff at the bedside. We identified one family who had not been updated by medical staff. However, this was not a consistent finding amongst all relatives and visitors, and the majority were very happy with the level of emotional care and treatment they and their loved ones had received.

# Critical care

The support continued following discharge home from hospital via the follow up team that supported patients after critical illness. The follow up clinic that the team provided had recently held a reunion event which had been well attended.

## Compassionate care

- All the patients and relatives we met spoke highly of the care they received. Due to the nature of critical care, we could not talk to as many patients as we might in other settings. However, patients we were able to speak with said they had found the staff caring and compassionate. Patients said they felt safe and supported. A patient we spoke with had found all the staff polite and caring.
- There was a calm atmosphere on the unit and the staff were seen to introduce themselves to patients and relatives, offer explanations and provide opportunity to ask any questions.
- We observed good attention from all staff to protect patient privacy and dignity. Curtains were drawn around patients and doors closed when necessary. Voices were lowered to avoid confidential or private information being overheard. The nature of most critical care units meant there was often limited opportunity to provide single-sex areas. However, staff said they would endeavour to place patients as sensitively as possible in relation to privacy and dignity. The unit were very aware of this issue and reported mixed sex breaches when patient transfers to the ward were delayed.
- The NHS Friends and Family Tests (FFT) asked patients if they would recommend the ward to their family and friends. These questions were usually asked when the patient was discharged from the hospital. As few of the patients were discharged from critical care (they usually went to a ward before ultimate discharge), they were not participating in the test. The unit had a form that provided a route for feedback to the staff about their experience particularly from patients' relatives and visitors. The forms were on display in the waiting room and included the following prompts:
  - What was good?
  - What could we have done better?
  - Is there anything would have improved your experience?

Completed forms were placed in a comments box in the waiting room and staff emptied this every week. We saw 11 cards that had been completed (between March 2014 and

November 2015) and they were all complimentary except one. This requested that the entrance to the unit via buzzer could be manned (March 2014). We were told that there were plans to increase the unit receptionist cover. However, this had not been achieved yet. The compliments included "cannot fault the care and expertise" and "my husband...received the best care we could have wished".

- We spoke with a family that were visiting a patient on the unit. They described the care as exemplary and the patient had been on the unit for a long time on a previous admission. They had been so impressed with the care that they had written to the local paper to say how fabulous the unit had been. Also a substantial sum of money had been donated by another ex-patient, which had been put towards the cost of the refurbishment of the unit.

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

- Staff communicated with patients and those close to them so they understood their care, treatment and condition. Patients were involved with their care and decisions taken. Patients who were able to talk with us said they were informed as to how they were progressing. They said they were encouraged to talk about anything worrying them. They told us communication was good, and this had extended to talking with their families. We observed staff, both doctors and nurses talking inclusively with patients and their relatives. Patients that were sedated and unable to communicate were also spoken to by staff, for example explaining what they were about to do.
- The views of relatives and carers were listened to and respected. However, a relative that we spoke with said that since admission to Radnor Ward, which was approximately two days previous, they had not been spoken with by any of the critical care doctors. The patient's communication record was blank. We reviewed five patient healthcare records and found that documentation regarding communication between the Radnor Ward team and relatives and visitors, was present in four cases.

## Emotional support



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- The team on the unit demonstrated that they appreciated the emotional turmoil that patients and relatives experienced due to critical illness and admission may cause. They provided a supportive, kind and unrushed approach.
- There was a specialist nurse for organ donation who was employed by NHS Blood and Transplant and was based at the hospital, to directly support the organ donation programme and work alongside the clinical team.
- The unit had a well-established follow up service and clinics were provided for patients and their relatives to attend. A clinical psychologist was available as part of the follow up team that supported patients after their discharge from critical care, in addition to being available for in-patients, their relatives and staff, and attending multidisciplinary team meetings. The staff had also arranged a successful event recently, where patients that had previously been to the clinic were invited to a reunion. We were told that over twenty people had attended.
- The unit supported the completion of patient diaries. These would be completed to capture the story of the patients stay on Radnor while they were too ill to be aware. When the patient recovered this could be shared with them.
- Chaplaincy support was available to the unit for anyone who required it. They often visited but could be contacted 24-hours a day in between these times.

## Are critical care services responsive?

Good



Critical care services were found to be good for responsiveness.

Aspects of the refurbishment and design of the unit had been made in collaboration with staff and local people. The facilities for relatives had been improved with a thoughtful inclusion of secure storage of valuables in the waiting area.

There was a well-established follow-up clinic for patients that had been discharged home after a critical care admission.

Despite the pressures on bed availability, patients were admitted to the unit in a timely fashion and the unit had

not transferred patients to other units for non-clinical reasons for over twelve months. Data from the Intensive Care National Audit and Research Centre (ICNARC) showed that the unit transferred less patients to the wards out of hours than the England average (performed better).

However:

Urgent surgical operations had been cancelled due to the lack of an available bed in critical care. This was above (worse than) the national average. Figures from NHS England reported 53 cancelled operations at the hospital between July and December 2015. However, none of the operations were cancelled more than once. We found there was no limit per day for how many beds could be booked on the unit for those patients that required critical care after elective operations.

There were delayed patient discharges due to a bed elsewhere in the hospital not being available. In the last five years between 60-70% of patients had their discharge from the unit delayed by more than four hours. This was broadly in line with the national average.

Not all bed spaces were capable of giving reasonable auditory privacy. There were no toilet or shower facilities for patients within the unit. However, patients were able to access these facilities in a neighbouring ward without entering a general public area.

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

- The unit did not meet all the recommendations of the Department of Health guidelines for intensive care units as they related to meeting patient needs and those of their visitors. These included:
  - not all bed spaces were capable of giving reasonable auditory privacy,
  - there were no facilities for patients who were well enough to have a shower or use a toilet. Patients were able to access shower and toilet facilities in a neighbouring ward, which could be accessed without entering a general public area.

However, there were areas that did meet the guidelines including:

- the main work base on the unit had a glazed screen to control noise transfer,



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- there was intercom-controlled entry to the unit. Entrances were locked and could only be opened by authorised hospital staff.
- The refurbishment had been designed to reduce delirium and anxiety with calming pastel colours and use of natural light. Families, doctors, nurses and allied health professionals were all actively involved in the design. Beautiful photographs taken by one of the consultants had been enlarged and used to decorate the unit.
- Relatives and visitors of patients being cared for on the unit had access to a waiting room with comfortable chairs. A new quiet room had also been created so that relatives and carers could spend time away from the bedside for reflection. There was also a kitchen, where visitors could make themselves hot drinks. There were some facilities available for relatives to stay overnight if required. Lockers had been installed to secure personal valuables such as handbags, while visiting patients on the unit.
- Visiting times were between midday and 8pm each day. However, they could be flexible to meet the needs of the patient and their loved ones. The policy was for only two visitors per bed space unless the patient was extremely poorly. There was limited space in the unit and visitors were asked to restrict numbers where possible. Visiting times prioritised the needs of the patient, while being supportive to relatives.
- Patients discharged from the unit had access to a follow up clinic. This was recommended by National Institute of Health and Care Excellence (NICE) guidance. The clinic was run by one of the units' consultants and was well established. A reunion event for patients that had previously been to the clinic had recently taken place.
- Translation services were obtainable and staff were aware of this and knew how to access them. They also had access to 'no verbal' cards which could be used to assist with communication.
- While some staff were able to describe the specialist support available at the trust for patients with learning disabilities, this was not universal. 'This is me' booklets were mentioned by staff. These booklets offered a practical way of informing staff about the needs, preferences, likes, dislikes and interests of a person. These can be particularly useful when caring for someone living with dementia. The booklets were not being used yet as there were plans to adapt it for use in the unit.
- A variety of information leaflets were available on the unit including about what to expect on intensive care for patients and relatives. These were printed in English. Some leaflets indicated how to get the information in another language or, for example, in braille. This service was accessed through a customer care free-phone number or email address.
- Patients on Radnor Ward who were able to eat and drink were given choices every day regarding what they would like for their meals and assistance provided as necessary, to enable the food to be eaten. A patient told us that the food was excellent.

## Access and flow

### Meeting people's individual needs

- Every day a care plan for patients was completed by nursing staff. These were individualised to meet patient's needs. Patients were seen to have access to a clock with date to help with orientation and a television set if required. A patient who was waiting to be transferred to a ward had been provided with a nurse call buzzer within reach, which could be used to request assistance.
- The unit had 12 physical beds, nine of which were funded and staffed, comprising five for intensive care patients (level three) and four for high dependency care (level two). Radnor Ward underwent significant refurbishment in 2014 increasing the number of physical beds from eight to 12. A draft operational policy describing elective and emergency admission procedures was provided by the trust.
- There was a process for booking elective beds following surgery. However, there did not seem to be a limit to how many elective beds could be booked each day. A bed booking sticker was completed and placed into a diary at the nurses' station. It included prompts to help review of the outcome for example, surgery cancelled. The last 11 stickers were checked and eight of them had been fully completed. This meant that the outcome of the booking was not always documented.
- Urgent surgical operations had been cancelled due to the lack of an available bed in critical care. This was above (worse than) the national average. Figures from

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NHS England reported 53 cancelled operations at the hospital between July and December 2015. This represented an average of just below 9 cancellations per month against an England average of just over 3 per month. However, none of these operations were cancelled for a second time.

- In the three months ending March 2015, 11 elective surgery cases were cancelled due to lack of availability of a post-operative critical care bed. This performance was much worse compared with other acute NHS trust figures. Performance had not significantly improved since the expansion of the unit to twelve beds, there were 20 patients cancelled between January 2015 and November 2015. Compared with the same number of cancellations on the eight bedded unit between April 2014 and December 2014 (nine months).
- Since the reopening in January 2015, the unit had around 32 patient admissions per month (six months ending June 2015). Just under half of the patients were ventilated (level three) on admission. The occupancy fluctuated between 50% and 100% however predominantly it had been around the national average of 80% (NHS England data from May 2013 and June 2015).
- There were many patient discharges delayed due to a bed elsewhere in the hospital not being available. Similar to most critical care units in England, data from the Intensive Care National Audit and Research Centre (ICNARC) reported a high level of delayed discharges from critical care. In the last five years between 60% and 70% of all discharges were delayed by more than four hours from the patient being deemed ready to leave the unit. This was broadly in line with the national average. Transfer within four hours was the standard recommended by the Faculty of Intensive Care Medicine Core Standards. Although patients remained well cared for in critical care when they were medically fit for discharge, the unit was not the best place for them. It also could delay access for patients who needed to be admitted, or meant the unit was at a higher occupancy than recommended. The delays were mostly less than 24 hours although some were longer. The rate of delayed discharges had been high for the last five years and at no point had been better than the national or similar-unit average in the last five years.
- Due to the delays experienced in accessing ward beds when required, there were patients that were transferred out during the night. The core standards for

intensive care units stated, discharge from should occur between 7am and 10pm. Three patients were transferred to the wards out of hours between July 2015 and September 2015 (according to ICNARC data). However, this was better than the national average (compared to other similar services). The bed manager visited the unit every weekday morning to find out if there were any patients ready to go to a ward bed.

- Despite the pressure of transferring patients out of the unit when ready for the ward, patients were admitted to the unit in a timely fashion. For example there had been no patients transferred to other hospitals to access a critical care bed due to non-clinical reasons in the year 2015. A patient requiring critical care should be admitted within four hours of the decision to comply with core standards for intensive care. Seven patients' healthcare records were checked and all had been admitted within four hours of the decision to admit time and had been reviewed by a consultant within 12 hours of that admission. One of the reasons for the refurbishment of Radnor Ward was the inability to nurse all the patients that required critical care on the eight bedded unit. Prior to increasing the number of beds available, patients waiting to be admitted were sometimes cared for by the Radnor Ward staff in theatre recovery. The trust informed us that since the expansion, no patients have been ventilated outside the unit owing to bed pressures. The number of beds in use for the unit was increasing. Between January 2015 and March 2015, seven beds were occupied 45% of the time and up to nine patients 4% of the time. Compared to the three months ending September 2015 where 90% of the time the unit had between four and eight beds occupied and on occasion had 11 beds in use (2%). At one point during the inspection, 12 patients were being cared for on Radnor Ward (three more than commissioned for). This demonstrated the unit's responsiveness to ensure critically ill patients were cared for in the unit and prevented the need for transferring patients (for non-clinical reasons) to another hospital to receive this care.

## Learning from complaints and concerns

- In the nine month period ending September 2015, the unit had received one formal complaint. Staff said that they had low numbers of complaints because they asked for early support and advice from senior managers in the division to attempt local reconciliation.

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- The formal complaint was from a patient that had a particular visitor without their consent. Due to their clinical condition, critically ill patients are often unable to inform staff about who they are happy to visit them during their stay on the unit. In response to the complaint practice was changed. In order to prevent people being allowed to visit whom the patient would not have wanted to; the patient (if possible) or the patient's next of kin were asked about this. The names of acceptable visitors were recorded in the healthcare records. Passwords were also set up to support this practice, which we observed in use during the inspection.
- In March 2014, a relative had completed a negative feedback form. This requested that the entrance to the unit via buzzer could be manned. There were plans to increase the unit receptionist cover however; this had not yet been achieved.

## Are critical care services well-led?

Requires improvement



The governance and leadership of critical care services did not always support the delivery of high quality person centred care.

Arrangements for governance of critical care services did not always operate effectively. For example, the risk register did not include risks that staff highlighted during the inspection and the risks had not been reviewed and updated. The governance structure and processes seemed immature and not embedded. In addition, it was not always clear how the local governance linked with formal trust wide processes. This meant that there was a risk that issues that required escalation were not being raised formally.

Following the refurbishment and recent changes in leadership of both nursing and consultant leads, the team seemed to be in a period of adjustment. The team culture was strong within the unit and the well-established follow-up clinic was used to actively seek the views of the public regarding critical care services. However, opportunities for staff engagement could be improved. For example, there were no unit meetings taking place.

## Vision and strategy for this service

- The unit had been through lots of changes in the last eighteen months. Whilst the extensive refurbishment was being carried out, the whole unit was moved to another ward on a temporary basis. When they returned to the refurbished unit the staff told us that new ways of working had to be evolved related to their new surroundings. The refurbishment was the culmination of the vision and strategy for the unit for some time and they now seemed to be in a period of adjustment.
- The unit had twelve physical beds and the funding and staffing to provide care for nine patients. Senior staff told us that the plans were to increase the funding for unit to provide six intensive care (level three) patients and four high dependency (level two) patients and increase staffing accordingly.

## Governance, risk management and quality measurement

- When refurbishing an existing facility, best practice is to comply fully with Health Building Notes (HBN 04-02). Critical care should be delivered in facilities designed for that purpose. However, if this was not possible, the reasons should be formally documented through the provider organisation's clinical governance process. A risk register for the planned refurbishment was developed. However, non-compliance with HBN or issues related to the new layout does not feature on the units current risk register.
- The governance structure and processes within critical care services seemed to be immature and not embedded. For example, the morbidity and mortality meetings started in October 2015. In addition, it was not always clear how the local governance linked with formal trust wide processes.
- There was no lead role for governance or policies and guidelines on the unit.
- The risk register for the unit required significant review and improvement. There were items that were past the review date. Some risks had not been updated following improvements, which significantly reduced risks. For example, the unit had changed to the use of radiopaque (opaque to X-rays) naso-gastric tubes to reduce the risk of incorrect placement. The risk had not been updated with this information. There were many risks that senior staff highlighted to us during the inspection, which had

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not been documented on the risk register, such as the lack of usable dishwasher. This meant that risks were not formally being monitored, mitigated and escalated through the risk register process.

- The critical care outreach team (CCOT) on the other hand, had a risk register specifically for them, which was up to date.

## Leadership of service

- Critical care services provided on Radnor Ward were managed under the umbrella of the surgical division in the trust.
- The leadership of the critical care service was in a transitional period. The unit met critical care standards by having a lead band eight nurse and a consultant in a clinical lead post. The long-term lead nurse for the unit had recently retired. The new senior lead nurse had started in their role on the same week as the inspection. The unit had also developed a deputy lead nurse role. This was initially a rotational post but now was to be permanent. The clinical lead consultant was also new in their role (since June 2015). The clinical lead consultant had been offered a management course to support them in their role, but they had declined.
- Clinical leadership of the patient's treatment and care was good from senior nurses and medical staff. During site visits, the nurse in charge of the unit was always supernumerary (did not have a patient allocated to care for) leaving them free to co-ordinate the shift. The nurse in charge also wore a badge, which alerted visitors to the unit who was managing the shift. According to core standards for critical care units there should always be a supernumerary nurse available (GPICS 2015) and we saw evidence on rotas that this was the case for the majority of the time. However, staff told us occasionally the nurse in charge had taken care of a patient. The frequency that this occurred was not documented. An additional recommendation is that units with more than 10 beds should have a further additional supernumerary nurse (GPICS 2015). On 4th December during the inspection there were 12 patients on the unit with one supernumerary nurse in charge. However, ICNARC data showed this did not happen often. For example, in the 3 months ending September 2015, the unit had 11 beds in use 2% of the time.
- According to core standards for critical care units there should always be a supernumerary nurse available. Radnor Ward was funded to provide critical care for nine

patients although they had twelve physical bed spaces. Intensive Care National Audit and Research Centre (ICNARC) showed that in the three months ending June 2015 the unit sometimes had 11 beds in use. As a minimum requirement, those units that have more than 10 beds, must have a further additional supernumerary nurse (core standards for intensive care). This standard was not being met. On 4 December 2015 during the inspection, there were 12 patients on the unit with one supernumerary nurse.

- Band 6 nursing staff had access to a local leadership development programme for Radnor Ward only. This comprised of four study days, shadowing site team leads and attending trust wide level meetings. This was well received by staff that we spoke with.
- There was a consultant nurse for critical care. This role was dedicated to critical care issues outside of Radnor Ward. The consultant nurse professionally supported the CCOT and was involved in strategic level plans for the trust including risk assessment for vulnerable patients, for example those with tracheostomy.
- We were told CCOT nurse were usually employed on band six and follow a development programme where progression is rewarded by promotion to band seven, based on merit.

## Culture within the service

- A strong supportive teamwork culture was evident within the service. This was clear from the medical staff particularly. They supported each other to ensure the unit was always covered despite the workload affecting the consultant's ability to cover.
- New nurses that joined the team told us that it was a positive supportive environment for learners.
- Staff described a respectful relationship on the unit between doctors and nurses. A nurse told us that they were really proud of the good care that was given by the unit to patients and their relatives.
- A trainee doctor we spoke with described the unit as a kind and friendly place.

## Public engagement

- There was an established follow-up clinic providing support for patients and relatives that had been through critical illness. This service actively sought patients' and

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relatives' views of the service, which were used to inform groups, such as the rehabilitation teams, in order to monitor service quality and identify improvement opportunities.

- Families were actively engaged regarding the refurbishment of the unit. This directly resulted in changes to the design of the unit including lights, colour scheme, and relatives' facilities (including lockers for their use). Relatives could also feedback to staff via comment slips that were in the relatives' waiting room. However, these did not appear to be used very often.

## Staff engagement

- Doctors, nurses and allied health professionals were all actively involved in the design and refurbishment of the unit. Ideas on how it was to look and function were obtained before. After the refurbishment staff were asked for their views on the unit and most comments were complimentary.
- Staff unit meetings had recently been abandoned due to poor attendance. Instead, emails and staff notices have been used for communication. A text message system enabled staff on the unit to contact all the nursing team through the computer. It was often used to see if anyone wanted to cover short-staffed shifts. Therefore there were limited formal opportunities for staff engagement.
- There was a structured approach to nursing teams within the unit. This meant that a senior nurse had a team of nurse allocated to them to support. These teams were also to be used for appraisals. However, we were told that 50% of staff had not received an appraisal in the last 12 months. Link roles were allocated to nurses and used by the unit to cascade information. There was a list on view in the coffee room.







- There had been an executive led quality and safety walk round on Radnor Ward in August 2015. This gave nursing staff and other support staff, the opportunity to raise issues directly to senior trust managers.

## Innovation, improvement and sustainability

- The trust had an award ceremony and Radnor Ward team won the 'Service Improvement Sponsored Project Award 2015'. This award was for the unit redevelopment.
- The unit had developed an innovative video for training staff about how to turn and care for patients in the prone position. It was a collaborative project with manual handling advisors, physiotherapists and nursing staff. This was available on the shared drive, which was accessible by all substantive unit staff.
- The unit had a rehabilitation and follow up team which included the appointment of a therapy assistant to support compliance with NICE guidance (CG 83). Specifically focussing on continuity following discharge to the wards.
- Implementation of critical care assistants posts and training programme
- Following refurbishment, the CCOT was based within the critical care unit to encourage collaborative working within the department and wider hospital, with CCOT attending MDT handover daily.
- Three members of the Radnor team plus the nurse consultant for critical care were on the faculty for the Bournemouth University critical care course, Ongoing clinical projects were linked to Bournemouth University, enabling individual members of the Radnor team to gain academic credit as part of the evidencing professional learning programme



# Maternity and gynaecology

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

## Information about the service

Salisbury Hospital provided a range antenatal, perinatal and postnatal maternity services in the hospital and within local community settings. The provision of maternity and gynaecology were managed within the clinical support and family services directorate of the trust. Choice of place of birth was limited to the hospital or patients home as the trust did not have a midwifery led birthing unit (plans were in place to develop this). The delivery suite at the hospital was consultant led and was able to provide care for women with low and high risk pregnancies and/or complex health problems. The community midwives were split into five teams covering a broad geographic area which bordered the Somerset, Dorset and Hampshire clinical commissioning areas.

There were nine delivery rooms, two rooms had a birthing pool and all the rooms had en suite showers. There was one triage room with an assessment couch and a four bedded antenatal bay which was used by patients during the day if increased observations and monitoring were required for short periods or on an inpatient basis. There was one dedicated maternity theatre with adjacent anaesthetic and recovery rooms. The anaesthetic room was further fully equipped to transform into a second delivery room in the event of escalation or emergency.

During the period April 2014 to March 2015, 2,446 babies were born, and 2,936 women received or planned to receive ante or postnatal care by the community midwives. This included women who chose to deliver at a different hospital. The majority of deliveries (2,360) were on the consultant led unit, and the remainder (86) were home

births. The average percentage of home births per month was 4%. During the period 1 April 2015 to 31 August 2015 there had been a further 954 births of which between six and nine per month were home births.

There was an early pregnancy unit with an ultrasound service which enabled pregnancies to be monitored, screening tests to be completed and potential problems diagnosed. These services were accessed on an outpatient basis. Antenatal patients who required increased monitoring were admitted to the delivery suite. Postnatal care for women needing to stay longer in the hospital was provided on Beatrice ward which had a seven bedded bay with shared bathroom facilities. There were an additional four single en suite rooms and a four bedded area for women who required a higher level of monitoring (total 15 beds).

A range of gynaecological investigations and treatments were provided. These included general and emergency gynaecology, and treatment for gynaecological cancer and abnormal bleeding. The majority of gynaecology patients received their treatment and care on an outpatient basis. During the past three years there had been approximately 650 emergency gynaecology admissions. Of these, 90% of patients length of stay was less than 24 hours and the majority (80%) were treated during week days. There was no dedicated gynaecology ward patients were admitted to a surgical ward. A termination of pregnancy service was provided. This was for medical terminations for fetal abnormalities up to 12 weeks of pregnancy. Women who required a medical termination for fetal abnormalities

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beyond this date referred to a specialist fetal medicine service for diagnosis, with the option of returning to the Benson suite for the termination. All surgical terminations were referred to a specialist service..

During our inspection we spoke with 13 patients, five relatives and a range of staff working throughout the gynaecology and maternity services. These included; consultant obstetricians, gynaecologists and anaesthetists, registrars, senior house officers, sonographers, the head of midwifery, lead midwives for community, screening, safeguarding and risk, labour ward coordinators, operating department practitioners, the specialist nurse for gynaecology, midwives, nurses, health care support workers, maternity support workers and ward clerks. We held a number of focus groups and meetings. Two were each attended by seven band five and band six midwives. We observed a staff handover on the delivery suite. We reviewed nine sets of patient records. Before, during, and after our inspection we reviewed the trust's performance information.

## Summary of findings

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

Care in both the gynaecology and maternity wards and delivery suite was consultant led. Patients had risk assessments completed and reviewed regularly. Incidents were reported and thoroughly interrogated for learning and safety improvements. Good safeguarding processes were in place, which included established links with the lead local authority. Staff demonstrated understanding of duty of candour regulations and compliance with this was also evidenced in records.

Safety improvements were required to the maternity services. The midwifery staffing levels did not meet the Royal College of Obstetricians and Gynaecologists (RCOG, 2007) Safer Childbirth Minimum Standards for the Organisation and Delivery of Care in Labour. The midwife to patient ratio exceeded (was worse than) recommended levels and one to one care for women in established labour was not evidenced to have been achieved 100% of the time. There was a lack of regular audit of the World Health Organisation surgical checklist. Retrospective audits completed used small samples (numbers of cases reviewed) and identified poor compliance levels.

The maternity services were responsive to the needs of local women. Positive feedback was consistently provided. This showed the majority of patients were highly satisfied with their treatment and care and would recommend services. We saw records documenting patient's choices and preferences. The maternity services had achieved full accreditation with UNICEF UK breast feeding standards. The gynaecology service had links with other specialists and treatment centres. This supported the provision of effective care and treatment plans for patients. Annual audit plans were in place which enabled clinical standards of practice to be checked and improvements made. Policies and procedures were provided in line with national guidance and policy.

# Maternity and gynaecology

There were thorough risk management and quality and governance structures in place. These linked departmental with trust risk and governance meetings. This ensured an effective flow of information from ward to board and vice versa. Incidents, audits and other risk and quality measures were scrutinised for service improvements and appropriate actions taken. Systems were in place to effectively share information and learning. Staff were proud of the patient care they provided and a learning culture was evident. Leadership was described as good. Junior staff told us they were well supported and senior managers were visible and approachable. The trust board had approved a capital investment in the maternity services. This included the provision of a new midwifery led birth unit.

## Are maternity and gynaecology services safe?

Requires improvement



Overall we have judged safety as requires improvement. This applied to the maternity services as midwifery staffing levels did not comply with the Royal College of Obstetricians and Gynaecologists (RCOG, 2007) Safer Childbirth Minimum Standards for the Organisation and Delivery of Care in Labour.. The midwife to patient ratio exceeded (was worse than) recommended levels. It was not possible to confirm if one to one care was provided 100% of the time for all women in established labour. There was an apparent lack of regular audit of the World Health Organisation surgical checklist. Retrospective audits reviewed small samples of clinical records and identified poor compliance levels.

Records contained clear plans of care, and appropriate referrals to other professions or services. Women had individual risks assessed and these were regularly reviewed. There was evidence of thorough investigating and learning from incidents. There was good evidence of staff understanding and following the Duty of Candour regulations. Staff were knowledgeable about safeguarding process and understood their responsibilities. There were established relationships with other safeguarding lead agencies. There was a safe level of consultant support available 24 hours a day, seven days per week across the gynaecology and maternity services to respond to emergencies and maintain oversight of women with high risks and/or complex health.

### Incidents

- The number of incidents in the maternity services had increased. From April 2013 to March 2014, 477 incidents had been reported. Between April 2014 to March 2015, the number of incidents reported was 530 (an increase of 53; 11%). Senior staff had monitored and analysed the types and severity of incidents reported. Staff were confident the rise was a consequence of reporting being completed more efficiently rather than an actual increase in incidents. This was supported by discussions with midwives. All of those we spoke with emphasised the need to report and learn from incidents in order to improve safety and outcomes for patients.

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- Between April 2015 and June 2015, 180 incidents had been reported by the maternity service. Analysis of this information revealed more than half of the incidents occurred during labour when care was least predictable. The types of labour incidents included, shoulder dystocia, post-partum haemorrhage and perineal tears.
- All the staff we spoke with demonstrated a clear understanding of the types of issues that should be recorded as incidents and told us they were actively encouraged to report incidents. All staff said they received feedback from incidents they had reported. This was completed on a one to one basis and through service wide emails and meetings. We looked at a selection of meeting minutes. These reported incidents as standard agenda items. This included the rates and types of incidents, changes to policy and specific learning.
- The gynaecology service referred to a trigger list of issues to be reported as incidents. These included a range of patient issues or harms such as delayed or missed diagnosis, anaesthesia complications, unplanned readmissions, unsuccessful procedures and failed equipment. The gynaecology staff demonstrated an understanding of incident processes. Investigations, outcomes and learning was evident in records.
- The trust followed the serious incident framework guidance from the Department of Health (March, 2015). This states an incident must be considered on a case-by-case basis against a revised description of serious issues. There were clear investigations and learning at departmental levels which was evidenced in root cause analysis (RCA) investigations and risk and governance meeting minutes. In addition, since January 2015 serious incidents were logged onto the national quality improvement programme 'Each Baby Counts' (2015) Royal College of Obstetricians and Gynaecologists.
- Records showed serious incidents had been robustly analysed and interrogated. Between May 2014 and April 2015 six serious incidents had been reported related to the maternity services. We reviewed the RCA investigations for four of these incidents. One incident was referred to the coroner's court who determined natural causes and the case was closed. At this point the maternity department could have concluded their own internal investigation. Senior managers continued with the intention of learning all that was possible from this serious and unexpected incident. The deep and probing

analysis revealed the possibility of other contributing factors. This information was passed back to the coroner who subsequently reopened the case for further investigation.

- We saw records which showed where recommendations had been made as a result of investigating serious incidents, action plans had been put in place. These included identifying responsible persons, timescales for completion of actions and what further evidence was required to show how learning had been shared widely within the department or with others as necessary.
- Perinatal mortality and morbidity (M&M) meetings and gynaecology M&M meetings were held every month. We looked at meeting minutes which detailed individual case reviews. Discussions were recorded between clinical staff regarding improvements to practice and procedures..
- The quality of the M&M meeting minutes was inconsistent. We observed the perinatal minutes were well organised. They included embedded PDF documents which provided clinical details of the patient case for discussion. A typed pro forma was completed which clearly documented discussions, learning points, and any necessary actions to be taken. The gynaecology minutes we were shown were hand written and lacked the same level of detail and discussion. Attendees were not consistently recorded. It was therefore difficult to review and establish how information (also limited) related to learning and outcomes had been agreed.

## Duty of Candour

- During November 2014, a new regulation was introduced to providers of NHS services. They are required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to incidents termed as 'notifiable safety incidents'. These were any unintended or unexpected incidents occurring to a patient leading to death, severe, moderate or prolonged psychological harm. This regulation requires staff to be open, transparent and candid with patients and relatives when things had gone wrong.
- Staff throughout the maternity and gynaecology services demonstrated an understanding of Duty of Candour. We asked a range of maternity and gynaecology staff, including the 14 midwives who

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attended the focus groups about Duty of Candour. All staff were clear regarding their roles and responsibilities when patient treatment or care had gone wrong or had not been satisfactory.

- Records evidenced Duty of Candour regulations were followed. In the four serious incident records we reviewed, all documented how patients and their relatives had been informed of and included in investigations. We observed if patients or relatives had particular questions that these had been asked and answered within the investigation reports.

## Safety thermometer

- The inpatient maternity wards (Beatrice) participated in the NHS safety thermometer. This was a process to collect patient safety information in relation to falls, catheter associated infections, venous thromboembolism (VTE), urinary tract infections, and pressure sores. Information provided by the trust confirmed from January 2014 to 30 November 2015 there were no recorded patient harms under these categories.

## Cleanliness, infection control and hygiene

- All ward and clinical areas in the maternity and gynaecology services appeared clean. We observed stickers were used on some equipment when it had been cleaned and was ready for use.
- Monthly hand hygiene audits were completed. Audit results were provided by the trust for July and August 2015. These covered the labour suite and day assessment unit, Beatrice postnatal ward and the gynaecology clinic areas. The compliance levels ranged from 89% to 100%. We saw a hand hygiene action plan was in place to improve and maintain compliance. This included use of a light box to ensure correct hand hygiene procedures were being used and a review of the training methods.
- The patients we spoke with had no concerns regarding the cleanliness of the environment. Patients confirmed they observed staff washed their hands and wore personal protective clothing such as gloves and aprons before providing treatment or care. Antibacterial hand cleaner was available throughout clinical areas. We observed staff washed their hands before and after providing care or treatment to patients.

- Cleaning staff had responsibility for floors, bathrooms and communal areas. Staff confirmed tasks were completed to a satisfactory standard.
- Equipment used on the delivery suite was visibly clean. The midwifery care assistants and midwives had responsibility for this and cleaned equipment in-between admissions. The two birthing pools looked visibly clean. These were decontaminated by staff after each use in order to be available for the next person using the room.
- There was evidence that processes were in place and followed to minimise infection control risks in the maternity service. The labour suite, ante and postnatal areas participated in the annual patient led assessment of the care environment assessment (PLACE). This external audit reviewed staff practices and the appropriate provision and maintenance of facilities and equipment used by patients. We reviewed the PLACE report dated January 2015. Clinical areas were assessed as clean and well maintained, with no visible dirt or debris evident. Staff were observed to be appropriately dressed and bare below the elbows. This reduced the risks of cross contamination and enabled effective hand hygiene to be completed.

## Environment and equipment

- The delivery suite environment was well organised, with equipment stored appropriately. All areas on the delivery suite were appropriate for use.
- The maternity and gynaecology wards were accessible with a swipe card for staff and controlled by a buzzer for patients and visitors. CCTV was used by ward clerks, clinical staff and security to staff to monitor for unauthorised access to the delivery suite and wards.
- There was an extensive bereavement suite in a separate corridor to the labour suite; this had a kitchen area and sitting room and three bedrooms, two of which were en suite.
- The antenatal day assessment and gynaecology outpatients' areas had all required and necessary equipment and was appropriate for use.
- The central delivery suite had adult and baby emergency resuscitation equipment. Cardiotochograph equipment for fetal heart monitoring were available for each delivery room. However there were only two baby resuscitaires for all nine patient rooms. We discussed



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this with senior staff who told us there had not been an occasion when this had impacted on the care needs of new born babies. Daily safety checks of this equipment were documented.

- There was adult and baby emergency resuscitation equipment and a baby resuscitaire on the postnatal ward (Beatrice). The adult resuscitation trolley had the necessary medicines and equipment was stored safely. Daily safety checks of the resuscitaire on Beatrice ward had not been fully completed. We looked at the records dated from the 30 October 2015 to the last entry dated 29 November 2015. There were gaps in the safety checks throughout this period of between one and four days.
- We observed there were limited computer on wheels (CoWs) within the delivery suite. These enabled clinical and other information to be reviewed and updated in the delivery rooms. For example; registering the baby for an NHS number. The midwives we spoke with told us they were often required to remain with patients. The lack of CoWs often delayed information being completed in a timely way when it was necessary to remain in the delivery room.
- We saw some equipment did not have in date maintenance checks. This included baby scales and delivery beds used by patients on the delivery suite.
- There was a lack of understanding regarding the processes for the maintenance of equipment within the maternity services. We discussed this with senior staff. There was reference to a central database. However, there was lack of clarity regarding when equipment had been serviced or if maintenance checks were in date and who had responsibility for oversight of this.

## Medicines

- Most medicines and controlled drugs were stored safely. We observed medicines stored in appropriately locked cupboards, and within the resuscitation trolleys, in the maternity theatres and other clinical areas. However, we found medicines on two separate occasions left in insecurely in rooms on the delivery suite. We alerted staff to this during our inspection. Midwives and nurses told us they had adequate stocks of medicines and no issues with the pharmacy services.
- Oxygen and nitrous oxide (used for pain relief) was piped into delivery rooms. Stronger analgesia was available for patients in labour if they required it.

- A protocol was followed for the safe storage of cylinders of oxygen and nitrous oxide at a patient's home. Records showed this was discussed with women prior to birth who signed to say they understood the conditions and instructions to be adhered to.

## Records

- Gynaecology and midwifery medical records and other confidential patient information was stored safely in lockable records trolleys. When records were not required they were stored in a central office which was locked when not staffed. The trolleys and office were accessible to all staff who required access to them. Staff told us they always had medical records in a timely way for clinical interactions with patients.
- We reviewed nine maternity patient records and the maternity safeguarding files. These records demonstrated clear plans of care. Documentations showed referrals to other professions or services had been made where necessary and information shared appropriately. There were no gynaecology inpatients at the time of our inspection, we therefore did not review gynaecology medical records.
- Midwifery record keeping was compliant with local and national standards. Between March 2015 and April 2015 an audit of midwives record keeping had been completed. A supervisor of midwives had reviewed 14 care records against standards set by the National Health Service Litigation Authority (NHSLA, 2012) and National Institute for Health and care Excellence (NICE, Quality Standards 22, 2012). The midwifery entries' were 100% compliant with standards.
- Records were not always completed in a timely manner. The maternity services regularly used the escalation process (redeploying clinical staff from other areas to the delivery suite) in order to safely meet the clinical needs of patients. Midwives told us patient care and treatment were prioritised and as such records were not always completed in a timely way. Senior staff were aware of these issues and in the process of recruiting additional midwives.
- The way the records were used and organised enabled clinicians to access relevant information to review care. Pregnant women had hand held records which were provided at their initial booking of ante natal care. These were maintained through to completion of

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post-natal care by community midwives. We saw all necessary risk assessments were completed and regularly reviewed. Risks were recorded as having been discussed with patients.

- Midwives took positive actions if hand held records were not available. We saw in one set of records that the patient had forgotten to bring with them to an antenatal appointment. The midwife wrote a clear summary of the appointment, discussion and actions to be taken. In addition the patients NHS number and date of birth were included. The summary was clear, factual, signed and dated by the midwife. This information had been added to the hand held records at the next consultation. This had ensured consistent records of clinical care were maintained.
- Systems were in place which ensured the legal requirements of a termination of pregnancy were pursued and documented in records. Processes were followed which ensured records were properly completed and forwarded as required to the Department of Health in a timely way. Stickers were used on records to indicate when specific parts of the process had been completed. This followed good practice guidance recommended by the Royal College of Obstetricians and Gynaecologists (2011).

## Safeguarding

- Staff we spoke with were knowledgeable about the trust's safeguarding process and were clear about their responsibilities. Staff demonstrated an understanding of what kind of issues might alert them to consider safeguarding issues, and what they could do to respond to the patient in a safe and supportive manner. We looked at records which showed when concerns had been identified, appropriate referrals had been made and these were fully documented. Records were discretely marked and IT information tagged in order that all clinicians involved in care were alerted to vulnerabilities. Detailed information was held securely by the lead safeguarding midwife
- Women were assessed for mental health issues as part of antenatal, perinatal and post-natal care. There was a midwife who specialised in working with vulnerable adults which included those with mental health needs. If issues were identified records showed, appropriate support was provided. Patients consent was sought to make referrals and share information with other professionals involved with their care.
- A revised perinatal and infant mental health pathway was in the processes of being implemented by maternity services. The first phase of this revised programme began during September 2015. This multiagency/multidisciplinary policy clarified the responsibilities and roles of the maternity service (and others) to prevent, detect and manage perinatal mental illness and infant mental health problems. This included clear and detailed ante natal and postnatal mental health pathways for women and young women under the age of 18 years. The lead midwife for safeguarding told us it was anticipated that all obstetricians and midwives would have completed update training by the end of January 2016. Other midwives we spoke demonstrated a clear awareness and understanding of the new policy roll out.
- The lead midwife for safeguarding was trained to the advanced level four in safeguarding and protecting vulnerable adults. This person provided advice and support to other staff when required. This included specific safeguarding supervision which was provided to midwives who were involved in safeguarding procedures.
- The safeguarding midwife had good links with the lead local authority safeguarding services. This midwife was a member of the strategic local authority children's board. We looked at the last meeting minutes dated November 2015. This documented the results and actions taken from a maternity vulnerable adult pathway audit. The minutes also documented how firm links with other local maternity services had been established. This ensured a consistent approach and response to safeguarding across all local services.
- There was no data available to confirm the level of compliance medical staff had with safeguarding children's training. Medical staff attended a whole days level three children's safeguarding training. This was facilitated by the trusts safeguarding lead nurse. The trusts data did not provide the levels of compliance with this training specifically for obstetric and gynaecology medical staff.
- There was no data available to confirm the level of compliance by obstetric and gynaecology staff for safeguarding vulnerable adults. This training was completed every two years as part of the trusts

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mandatory training programme. The trust provided information of an overall compliance rate for all mandatory training by all staff groups. This figure was 76% against an overall compliance target of 85%.

- The lead midwife for safeguarding facilitated a rolling programme of level three safeguarding children update training for midwives. During 2015, six, two and half hour sessions had been planned. Midwives were rostered to attend this training and only did not attend if absent from work. The lead midwife for safeguarding told us by the end of December 2015, 90% of midwives were expected to have completed the safeguarding update.

## Mandatory training

- The trust provided a range of statutory and mandatory training for staff which were allocated based on roles. This included training on dementia, equality and diversity, moving and handling, safeguarding adults which included mental capacity and deprivation of liberty safeguards, and infection control. The trust provided information of an overall compliance rate for all mandatory training by all staff groups. This figure was 76% against an overall trust compliance target of 85%.
- Maternity staff attended an additional day's mandatory skills and drills prompt training (practical emergency obstetric training). This was a multidisciplinary, evidence based and accredited training package PROMPT (RCOG and RCM, 2013). This included the use of a simulation model which was used to recreate emergency scenarios. Records showed 95% of midwives and 100% of consultants were compliant with this training. Midwives spoke extremely positively about the quality of this training, stating it enhanced team working, learning and confidence.
- The midwives attended further mandatory training in Neonatal Advanced Life Support as required by the UK Resuscitation Council and attended annual update training. The compliance rate during November 2015 was 74%. We spoke to senior staff about this. We were told at times of escalation on the delivery suite; staff had been redeployed from training. Additional midwives were being recruited at the time of our inspection.

## Assessing and responding to patient risk

- All pregnant women had comprehensive risk assessments which were started at the first booking appointment. We spoke with community midwives who told us they provided an extended booking time. This

was to ensure issues or risks were identified and actions to mitigate these were initiated. Risk assessments and action plans were reviewed with every subsequent contact with a doctor or midwife. This included screening for pre-eclampsia, gestational diabetes, venous thromboembolism, and other medical conditions. Other risk factors were assessed and discussed with women including; previous obstetric history, family medical history, social issues, and screening for domestic abuse and mental health.

- Clinical leads maintained regular review of the complexity of patients on the delivery suite. The Birthrate Plus acuity tool was used by senior staff every four hours to risk assess the needs of patients against staffing levels. Birthrate Plus is a nationally recognised tool (reflected in DH and NICE guidance) used to provide assurance that staffing levels safely meet service needs. The acuity tool was used as evidence for invoking the escalation policy. This policy enabled staff roles and responsibilities to be reorganised and redeployed to reduce risks and meet patients' needs. This included the community and ward midwives, and if required, the specialist midwives and the head of midwifery.
- The central delivery suite was consultant led and able to support women with high risk pregnancies and/or complex health. Women assessed as having low risks who chose a home birth and developed unexpected complications were transferred immediately to delivery suite at the hospital. Between April 2015 and October 2015 there had been 22 (average; two per month) intrapartum or postpartum transfers of women from home to the hospital.
- Systems were in place to respond to acute, severe and unpredictable obstetric emergencies. Anaesthetic and obstetric medical staff were available 24 hours a day, seven days per week. We observed on call contact information was available to staff.
- The anaesthetists from the hospitals surgical department who covered on call received regular obstetric updates to maintain their skills. These were monitored and reviewed through their annual appraisals.
- On call consultant obstetricians and anaesthetists were contractually obliged to be on site within 30 minutes of the call. We observed daily safety briefings were conducted twice per day on the labour suite and postnatal ward (Beatrice). We looked at records which showed a range of issues were reviewed and actions

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taken. For example, patient acuity (level of need), staffing levels, equipment and security issues, safeguarding issues, theatre activity and cover and availability of the neonatal unit.

- Consultants and midwives were familiar with guidelines for the management of conditions such as cord prolapse and post-partum haemorrhage. We saw records which showed emergency skills' training was completed annually by medical and maternity staff.
- The paediatric medical staff reviewed care on a daily basis. The paediatricians were in regular contact with the delivery suite and visited the antenatal ward (Beatrice) each day. This ensured the neonatal intensive care unit were aware of any potential issues. Records were maintained on Beatrice which documented paediatric clinical reviews had been completed in a timely manner.
- On the delivery suite there was adult and baby resuscitation equipment and sufficient cardiotochograph equipment for fetal heart monitoring. We observed 'fresh eyes' stickers had been signed to confirm trace readings had been double checked by a second midwife. These actions ensured any additional concerns or actions could be promptly responded to.
- There were processes and equipment in place for the safe transfer of newborns requiring additional or specialist support. The neonatal intensive care unit (NICU) was situated next to the delivery suite. Paediatricians were available within minutes if required. There was a baby transporter incubator/resuscitation unit. This was used if a newborn required transfer to an alternative service for specialist treatment.
- Safe practice guidance was followed before obstetric surgery commenced. We observed the World Health Organisation (WHO) surgical safety checklist being used in theatre. The guidance prompted actions for safe clinical practice before anaesthesia, before incisions, and before the patient left the operating room. Theatre staff appeared familiar with processes and participated appropriately. The safety checklist also formed part of the obstetric theatre team brief. This gave clinicians additional opportunities to discuss and plan for any issues relating to the safety of patients. We spoke to medical and theatre staff regarding the use of the safety checklist and theatre team brief. Staff told us compliance with both was well established and embedded in practice.

- There appeared to be a lack of regular audit of the WHO checklist to evidence compliance levels. We reviewed a retrospective audit of women's maternity records dated September 2015. The sample size was small; with only 10 records reviewed. Compliance with the required actions were poor ranging between 33% and 83%. Actions were put in place including raising staff awareness and adding a signature box to more clearly identify who was responsible for completing the checklist. A second small audit was repeated during December 2015. This was an observational, real time audit of eight patients. The compliance rate was recorded as between 87% and 100%. We were told the action plans were being developed
- Obstetric risk management guidance tools were available, used and appropriately referenced to other national standards and guidance. For example; we saw records of risk assessments completed for venous thromboembolism, safe induction of labour, and for women who had had previous caesarean section.
- Staff demonstrated an understanding of gynaecology emergency risk management guidelines, and knew how to access these for reference. We observed guidelines were based on national best practice standards and guidance. For example, National Institute for Health and Care Excellence (NICE) clinical guidance 154 on the management of ectopic pregnancy and miscarriage.

## Midwifery staffing

- There were 78 whole time equivalent (WTE) midwives supporting the provision of maternity and obstetric services within the trust and local community. This included a head of midwifery, a safeguarding midwife for children, a midwifery advisor for vulnerable women, an antenatal screening coordinator, a specialist newborn hearing screening midwife, an infant feeding specialist, a deputy head of midwifery and practice development midwife, and an audit and complaints lead midwife.
- There were inadequate numbers of midwives to meet the Royal College of Obstetricians and Gynaecologists (RCOG, 2007) Safer Childbirth Minimum Standards for the Organisation and Delivery of Care in Labour. This recommends a midwife to patient ratio of 1:28 for safe capacity to achieve one-to-one care in labour. During the period May 2015 to October 2015 the midwife to birth ratio ranged between 1:33 and 1:41, with the average being 1:37.5. No audit or analysis information

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was collated to establish if one to one care was achieved for all women during established labour. We discussed this with the head of midwifery who told us they were confident this was provided through the use of the escalation process. However, it was not possible to establish these facts.

- Shortfalls in midwifery staffing were covered from substantive midwives temporarily increasing their hours. If staffing issues were not resolved this way, the maternity escalation policy was followed. This required the community and ward midwives, and if required, the specialist midwives and head of midwifery to be redeployed to fill any staffing gaps. Senior midwives confirmed the escalation policy had to be used most days, and staffing issues were a concern. We saw records which showed this had been entered on the risk register.
- During 2014/15 the trust commissioned Birthrate Plus (Royal College of Midwives, 2006) to review the funded establishment of midwives within the maternity services. Data was collected during a four month period and the findings indicated a shortfall of 10 WTE midwives. In response, the trust committed to the immediate employment of five band five midwives and five band six midwives. At the time of our inspection, the department had recruited the band five midwives (included in the 78 WTE figure) and had advertised for the band six midwives. Once all vacancies had been filled, the funded establishment would have increased to 83 (WTE). The head of midwifery told us this would take the birth to midwife ratio to 1:32. We were told this ratio was agreeable with the local clinical commissioning group.

## Medical staffing

- There were safe levels of medical staffing. The trust had 19 whole time equivalent medical staff who worked across the gynaecology and obstetric services. There were six (WTE) consultants who provided 40 hours of obstetric cover per week. This met the recommendations of the RCOG Safer Childbirth, The Future Workforce (2007).
- There were sufficient anaesthetic, obstetric and gynaecology medical staff to provide surgical and clinical support to at all times. This was managed through an on call rota. However, the registrars were on call one night in every six. The local medical deanery was concerned as this rate had been impacting on the

programme of educational and clinical teaching. These issues had been presented to the trust board who had approved the appointment of two resident consultants. Once in post it was anticipated the on call responsibilities would reduce to once every eight days.

## Other staffing

- Senior staff said there were sufficient staff employed in roles which supported the midwifery and gynaecology services such as sonographers and ward clerks.
- The theatre staff from the hospitals surgical department were rostered to work in the obstetric theatre.
- There was one WTE specialist gynaecology nurse, a part time band five nurse, (0.32 WTE) and band three health care support workers (1.85 WTE).
- There were 17.07 WTE band two midwifery care assistants and four WTE band three posts.
- There was a low use of bank staff in the maternity unit. Between April 2014 and March 2015 the use of bank staff remained consistently below 1%. No maternity agency staff had been used.

## Major incident awareness and training

- Senior staff demonstrated an awareness of the trusts major incident plan and how to access this, but had not been included in training.

## Are maternity and gynaecology services effective?

Good



Overall, we have judged effectiveness as good in the maternity and gynaecology services. Policies and guidelines had been developed in line with national policy. These were available on the trusts intranet and staff demonstrated they knew how to access them. A range of equipment and medicines were available to provide pain relief in labour. The midwifery services had achieved full accreditation with UNICEF UK breast feeding standards. The gynaecology service had good processes in place to promote and maintain effective care and treatment. There were opportunities to improve some midwifery competencies and obstetric multidisciplinary team working.

## Evidence-based care and treatment



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- We observed policies and guidelines in the maternity and gynaecology services had been developed in line with national policy. These included a range of National Institute for Health and Care Excellence (NICE) guidelines, the Royal College of Obstetricians and Gynaecologist; Safer Childbirth (RCOG, 2007), The Care of Women Requesting Induced Abortion (RCOG, 2011) and the Termination of Pregnancy for Fetal Abnormality (DoH, 2010) guidance. Patients received care in line with NICE quality standards 22 (for routine antenatal care), 32 (for caesarean section) and 37 (for postnatal care).
  - Policies and procedures were available on the trusts intranet and staff demonstrated they knew how to access them. However, the intranet system was slow to load up and delayed prompt access by staff. Gynaecology staff told us they had printed many policies and procedures in order to be assured the team had easy access to information when required. The lead gynaecology nurse took responsibility for ensuring these were kept up to date.
  - The gynaecology and maternity services had audit programmes in place. This included local clinical audits and participation in national clinical audit. These enabled the services to evaluate if treatment and care was being provided in line with national standards and to identify improvement actions.
  - The maternity audit plan was extensive and included audits completed in previous years and others planned to take place during 2017. There was a range (22) of audits dated from 2014 to 2016 at various stages of progress, planning and completion. We reviewed one audit report dated April 2015. This had analysed how information was recorded on cardiotocography printouts (monitoring of the fetal heart). This provided an overview of standards and staff practice. Further actions and learning from this audit had been presented at the maternity governance meeting and shared with staff.
  - We observed an audit tracking system for 12 obstetric related NICE guidelines. This identified how practice was being delivered to patients in accordance with NICE. This had been established through baseline audits comparing current practice to that recommended. Where required, action plans had been put in place and re-audit planned.
  - New or updated national or trust guidance was communicated to staff via meetings and email. We observed policy and procedure updates were included in meeting minutes and the weekly maternity staff update emails.
  - The termination of pregnancy service was provided in line with RCOG (2011) evidence based clinical guidance and standards. These included a pathway of assessment, treatment and support before, during and after procedures.
  - All gynaecology cancer patients received appropriate care which followed national standards and guidance. This included NICE improvement outcomes guidance, 2003 (for ovarian cancer) and 2004 (for gynaecology cancer), and The Cancer Reform Strategy, 2007. Before patients started treatment plans, they were discussed and signed off by a regional specialist cancer centre.
- ## Pain relief
- Patients we spoke with told us they regularly had their pain assessed by staff and were given medicines promptly. We looked at patient care records and saw pain and comfort needs had been assessed.
  - A range of pain relief was provided on demand in the delivery unit. Each room had an electronic delivery bed which could be adjusted to support different positions and ease pain. Nitrous oxide gas (Entonox) and oxygen were piped into each delivery room. Epidurals and other pain relieving medicines were available for patients in labour 24 hours a day, seven days a week. Midwives confirmed anaesthetist's responded promptly.
  - Additional resources were available to relieve pain and support a natural delivery. Water was used to alleviate pain and birthing pools were available in two of the delivery rooms. A range of equipment was available including; a birthing couch, bean bags, birthing stools and mats and large sit on balls. Approximately half of all midwives had been trained to use aromatherapy as an option available to reduce and alleviate stress and anxiety.
  - Pain relief options were planned in advance and with patients on the delivery suite and birth centre. We observed birthing plans had been completed between patients and clinical staff in advance of delivery. This included discussions regarding pain management.
  - Midwives told us pain management options and choices were regularly reviewed during labour. We saw this was documented in care records.

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## Nutrition and hydration

- The maternity services had full accreditation (level 3) with the UNICEF UK Baby Friendly Initiative. This meant staff had fully implemented breast feeding standards which had been externally assessed. This involved interviewing mothers about the care they had received and reviewing policies, guidance and internal audits.
- On the postnatal ward (Beatrice) there was a dedicated baby feed fridge. We observed ample stocks of breast pumps which were available for use by patients if required.

## Patient outcomes

- The majority of deliveries (2,360) were on the consultant led unit, and the remainder (86) were home births. The rate of home births was the highest in the south west region. The average percentage of home births per month was 4%, significantly higher than the average national average of 2.3% (Office of National Statistics, 2014). During the period 1 April 2015 to 31 August 2015 there had been a further 954 births of which between six and nine per month were home births.
- Women were encouraged to breastfeed following best practice guidance. The uptake of breastfeeding at the hospital exceeded (was better than) the national average which was 74.35% (NHS England, July, 2015). Records showed between July 2014 and June 2015 the average percentage uptake of breastfeeding by women supported by the maternity services was 81%.
- Treatment and care was provided in a timely care. All babies were required to have a neonatal examination within 72 hours of birth. These were performed by paediatricians. We saw records on the postnatal ward confirming the majority were completed the same day they were requested by midwives. In addition we were told approximately half of all midwives had completed specialist training to provide the newborn checks. This supported the prevention of discharge delays.
- A range of effective and timely gynaecological investigations and treatments were provided. These included general and emergency gynaecology, and treatment for gynaecological cancer and abnormal bleeding. The colposcopy service (treatment following positive cervical smear tests) provided a prompt and effective service. The hospitals referral to treatment times were exceeding (were better than) the national average rates. We looked at audit information dated

April 2014 to March 2015. Standards were set for urgent, moderate and routine appointments. National guidelines recommend 90% of patients should have had an appointment within set time frames based on urgency (NHS Cancer Screening Programmes, 2010). The target times achieved at Salisbury hospital were between 95.5% and 100%. In addition, test results and treatment plans were provided to patients in a timely manner. The percentage shared within four weeks of attendance was 97%. This exceeded (was better than) the national target of 90%. The percentage shared within eight weeks was 99.5%, against a national target of 100%.

- The rate of unexpected admissions of full term newborns to the neonatal intensive care unit (NICU) was monitored and investigated for learning and safety improvements. Staff said it was difficult to establish the threshold for unexpected admissions to NICU as they included those transferred there for safeguarding reasons. From April 2014 to March 2015 the percentage ranged between 2% and 5%. Between April 2015 and August 2015 the transfer percentages ranged between 1% and 4%.
- Between April 2014 to March 2015 there had been one unplanned maternal admission to the intensive care unit (ICU). We saw records which showed this had been subject to both an in depth internal and coroner's investigations. Between April 2015 and August 2015 there had been no unplanned maternal admissions to the ICU.
- The maternity services maintained a red, amber, green (RAG) rated dashboard of clinical outcomes. This related to birth figures and complications during perinatal care. The parameters were based on RCOG recommendations. Some of this clinical data had been adjusted further. This was based on analysis of Salisbury Hospital's data during a three year (minimum) period. For example, the national average home birth rate was 2.4% (Office for National Statistic's, 2014). The average homebirth rate for Salisbury hospital had been higher. Therefore the threshold for home births was adjusted to 4% to reflect this.
- We reviewed the clinical dashboards for the period April 2014 to March 2015 and April 2015 to August 2015. The rate of elective and emergency caesarean sections was 24% which was below (better than) the national average of 26%. The rates of third and fourth degree perineal tears were measured together using the RCOG guidance.

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This recommends rates should account for less than 5% of deliveries. During 2013/14 the rate was 3.9. From April 2014 to March 2015 the rate had decreased to 3.4%.

Records showed all incidents of this type had been reviewed. Analysis had not identified any significant contributing factors other than the body mass index of patients at Salisbury hospital (a recognised indicator, RCOG). The national average rate for postpartum haemorrhage (PPH) was between 1% and 5% of all births. The rate of PPH at Salisbury maternity services was hospital was 1.8%.

- The maternity service participated in the Maternal, Newborn and Infant Clinical Outcome Review Programme (MBBRACE). We reviewed the most recent report dated November 2015, reviewing data from 2013. This analysed the rates of stillbirths based on a calculation of percentage per 1000 births. During 2013, this was 3.6% (nine stillbirths). Between April 2014 and March 2015 the rate was 4% (10 stillbirths). Whilst these figures were higher compared to other similar sized trusts. The rates were slightly below the south west regional average of 4.1% and the national average of 4.7%.
- All stillbirths were fully investigated as part of serious incident reviews and reported onto the national quality improvement programme 'Each Baby Counts' (RCOG, 2015). In addition Salisbury maternity services had completed two reviews to interrogate for themes or trends, and make any necessary changes to practice. The most recent report included all stillbirths which had occurred between January 2012 and December 2014. A range of data was scrutinised using a validated proforma (British Journal of Obstetrics and Gynaecology, 2011). This included analyses of demographics, previous pregnancy history, obstetric risk factors, social issues, antenatal and intrapartum care. Overall, no new trends were identified and an action plan was put in place and shared with staff to reinforce areas of good clinical practice.

## Competent staff

- Clinical expertise and support was available to junior medical staff and midwives. Junior staff said they felt supported. For example one doctor explained how they had performed a complex procedure. We were told the consultant had sat outside the theatre while this was completed. The doctor said this had provided a good balance of learning with immediate support available if

required. There was experienced labour manager/coordinator and a community midwifery manager. These roles provided additional clinical expertise to more junior staff.

- There were good processes in place to maintain the skills and competencies of gynaecology staff. The consultants met every month to present their own gynaecology cases. This formed part of a peer review process which positively promoted the development and clinical skills.
- The gynaecology lead nurse took responsibility for ensuring the health care support workers and band 5 nurses had the necessary competencies and skills to effectively support patients. This included providing skills training sessions, supervision and support and ensuring policy updates were understood.
- The gynaecologists had processes in place to develop skills and clinical practice. The team had established working relationships with other specialists external to the service. Each week at least one of the senior clinicians joined a large multidisciplinary meeting taking place at another hospital via video conference. This was attended by a number of gynaecology specialties who worked within the south west region. The purpose of these meetings was to review clinical work, get advice and support, discuss potential referrals to others and share good practice.
- Not all staff were being supported to have an annual appraisal. Records dated November 2015 showed 64% of midwives had a trust annual appraisal in date. This did not meet the trusts target compliance target of 85%. Senior staff told us frequent use of the escalation policy and prioritising safe patient care had impacted on the completion of appraisals in a timely manner. Staff assured us appraisals were being scheduled.
- The ratio of supervisors to midwives (SoM) met recommended guidelines. The regulation of midwives includes an additional layer of investigative and supervisory responsibilities provided by a supervisor of midwives (SoM). By law midwives must have a named SoM with whom they meet once a year to consider their practice. The recommended ratio of SoM to midwives was 1:15 (Midwifery Rules and Standards, rule 12, Nursing and Midwifery Council, 2014). There were ten SoM which gave a ratio at was 1:12. Records showed the

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percentage of completed SoM reviews was between 78% and 100%. Staff told assured us SoM appraisals were scheduled for those midwives who still required them.

- There was a SoM available on call 24 hours a day, seven days per week to support midwives with clinical practice issues. Midwives confirmed supervisors were responsive when contacted for advice.
- There were a number of experienced specialist midwives who had completed additional training and had enhanced skills. This included midwives for: safeguarding children, vulnerable women, antenatal screening, newborn hearing screening, infant feeding, practice development, audit and complaints and bereavement. These midwives had lead roles for their specialties, providing clinical updates, audit information, advice and support.
- The senior gynaecology nurse was skilled and experienced. This person ran their own colposcopy clinic once per week. This involved taking patients from referral through to discharge and independently providing diagnostics and treatment.
- Systems were in place to ensure junior midwives had the required skills for practice. Newly qualified band five midwives completed a preceptorship programme during the first year in post. This was to enhance confidence and competence in order to provide safe, effective care to patients. Once competencies had been fully reviewed and signed off, these midwives progressed to band six posts with increased independent working and responsibilities. This practice followed the recommendations in the Preceptorship Framework (Department of Health, 2010). We spoke with a junior midwives. We were told the training and support provided was of a highest standard. When junior midwives reported for duty the most senior midwife identified themselves and ensured any additional clinical support was provided. We were told the practice development midwife was approachable, was a good listener and had an open door policy. This person supported junior midwives to find or create their own action plans to move forward with issues and professional development.
- Not all midwives felt confident to practice in all areas of care. There was no planned midwifery rotational working programme (between community, delivery suite, ante and postnatal care). The band six midwives only rotated from their main place of work if this was

requested and, if there was the capacity to accommodate this. Therefore some midwives, who had developed skills in specialist areas, remained in their roles long term. However, during busy periods when the escalation policy was used, all midwives were considered for redeployment to other clinical areas to meet service demands.

## Multidisciplinary working

- Maternity staff reported good multidisciplinary working when delivering direct patient treatment and care. However, there were missed opportunities for multidisciplinary working on the delivery suite. The midwifery and medical handovers were held at different times. In addition, we observed when medical handovers took place, these were completed by medical staff privately (in closed rooms; unit meeting minutes dated July 2015 and September 2015). Therefore, the whole multidisciplinary team was not able to benefit from each other's handover. This may have reduced the potential for developing staff knowledge and skills, and for effective patient communication and coordination of treatment and care.
- Whilst all staff confirmed they worked cohesively to deliver patient care, we were told this did not always extend to other working practice within the department. Many maternity staff felt there was a hierarchical approach between medical and midwifery staff which was felt to have a negative impact on whole team working.
- We observed a morning medical handover meeting. This was attended by the labour ward coordinator, medical and anaesthetic staff. During the meeting the clinical needs of patients booked for induction and /or elective caesarean sections were reviewed. All staff engaged and participated in discussions, which were productive and well managed.
- Information was shared appropriately with other professionals and services for the benefit of patient care. Some of the records we reviewed showed clear and detailed communication with other external services. For example, we saw information shared by the safeguarding midwife with the local authority.
- The gynaecology team worked cohesively. Team members told us there were effective systems of communication and respect shown between all staff

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which benefited patient care. For example, the nursing assistants joined and contributed to clinical meetings. In addition they were competent and confident to question and raise concerns or issues with consultants.

- The elective caesarean section lists were accommodated by a dedicated surgical team. The team worked effectively with maternity staff to coordinate and manage obstetric surgical procedures. For example, when emergency sections had to be accommodated and the surgical lists had to be revised.
- The midwives worked effectively with services in the community. Antenatal and postnatal care was offered in the woman's home, at a children's centre or GP surgery. Information was shared in order to improve outcomes and ensure consistency of care.
- Postnatal care in the community was coordinated effectively. The community administrator had systems in place to keep the community midwives updated. These processes ensured clinical information was shared in a timely way. For example, sonography and other test results and delivery and discharge information. This supported a seamless transition of care from the acute to the community setting.

## Seven-day services

- The central delivery suite was staffed 24 hours a day, seven days per week. The maternity services had not closed from January 2014 to November 2015.
- Obstetric and gynaecology services were consultant lead and provided 24 hour emergency clinical and surgical care, seven days per week. A middle grade doctor was on site 24 hours a day and had responsibility for emergency admissions to the labour suite and any gynaecology inpatients. Overnight the duty consultant could be contacted at home and was available to come into the hospital. All of the obstetric consultants lived within a 20 minute travel time to the hospital.
- The maternity day assessment and ultrasound unit were open during week days. Out of hours imaging was provided by the hospital's main imaging department.

## Access to information

- Medical records were accessible and available for both gynaecology and maternity clinics. Reception staff told us previous medical records were requested and were supplied and checked before clinics. This ensured staff had relevant information required.

- Pregnant women carried their own records which were provided during the initial booking appointment. These were used by all clinicians involved with care during the pregnancy. After delivery, new records were made which included relevant information regarding the pregnancy, birth and baby. These records were carried by women and used for post-natal care.

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

- Staff followed the correct processes to gain consent. The patients we spoke with confirmed that staff had asked for permission before proceeding with any care or treatment.
- Procedures to gain consent were documented. The nine care records we reviewed clearly documented discussions regarding consent before carrying out any examination or procedure.
- Not all staff were in date with trusts mandatory training on the Mental Capacity Act 2005 and Deprivation of Liberty safeguards. This formed part of the safeguarding vulnerable adults training. The trust provided information of an overall compliance rate for mandatory training by staff groups. This figure was 76% (November 2015) against an overall compliance target of 85%.

## Are maternity and gynaecology services caring?

Good



Overall, we have judged caring in the maternity and gynaecology services as good. Staff cared for pregnant women before, during and after birth with kindness, compassion, dignity and respect. Patients told us they felt involved with their care, had their wishes respected and understood. The support provided to patients and families was person centred, compassionate and sensitive. Feedback from patients and relatives regarding the care, treatment and support received was consistently positive.

## Compassionate care

- The monthly Friends and Family Test results were consistently positive. Feedback was sought from those patients using; gynaecology outpatients, antenatal clinics, the delivery suite, care provided for home births, the postnatal ward (Beatrice), and postnatal care



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provided in the community. We looked at records dated November 2014 to October 2015. The average response rated during this time was 13.9% and the average percentage of patients who were satisfied with their care and would recommend the service was 97%.

- Five of the patients we spoke with had chosen to have subsequent births at Salisbury hospital because their previous experiences had been so positive.
- Compassionate and sensitive care was provided to families who had experienced the loss of a baby, including women who used the termination of pregnancy service.
- Many of the patients we spoke with commented that when they arrived for maternity appointments, reception staff were welcoming, friendly, helpful and kind.
- We observed compassionate and person-centred care provided to patients. We saw staff knocked on doors before entering rooms and spoke kindly and appropriately with patients.
- We saw recent letters and cards from patients expressing grateful thanks for the care received.
- There were opportunities for patient privacy to be improved. On the delivery suite and postnatal ward (Beatrice) we observed that no indicators or signs were used to show when patient rooms on the delivery suite or Beatrice ward (postnatal) were occupied. Staff told us they had to continually check for updates.

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

- Most of the patients within the maternity services we spoke with told us they felt involved in their care, and that information had been presented in meaningful and understandable ways. One patient told us their appointments with the consultants and midwives were never rushed and they were given written information, encouraged to ask questions and told to go away and think about choices and options before making decisions.
- We spoke with five partners of women who said they felt included and had been given explanations of care as it was occurring which they had found helpful and reassuring.
- We looked at nine patients' records and saw discussions and treatment plans were documented as discussed with patients and where appropriate, with those close to them.

- Ward and clinical areas were relaxed and we observed staff had friendly but respectful interactions with both patients and relatives.

## **Emotional support**

- The majority of patients were satisfied with how they were supported in the maternity services. We spoke with 13 patients and five partners. Comments included that staff had been friendly, supportive and helpful. Partners told us they were included and supported to participate with the birth process. One patient told us they had a fear of hospitals, but staff had been extremely reassuring and helpful. This patient said they subsequently felt sufficiently relaxed and comfortable to be able to have achieved their preferred birth plan.
- The Benson bereavement suite was staffed by midwives. There was one lead identified midwife with specialist interest and skills to support with bereavement and loss. This midwife, together with the chaplaincy services and three other midwives with specialist interest in grief and loss provided direct support to patients or advice and support to other midwives as required.
- A range of caring and thoughtful mementos were available to patients and their relatives to support with bereavement and loss. Staff provided personalised memory boxes and specific blends of aromatherapy oils for patients to take home when they left the Benson suite. A camera was available and patients were provided with the camera's memory card. In addition, a medical photographer was available 9am to 5pm Monday to Friday. Staff told us this person worked sensitively, producing beautiful photographs in response to patients' personal requirements. One of the mortuary technicians was also able to provide plaster foot casts.
- The specialist midwives provided counselling and support to women undergoing antenatal screening. Women who attended for termination of pregnancy for fetal abnormalities were provided emotional care and support by midwives on the Benson suite.
- We observed midwives and medical staff supporting women on the telephone, within the obstetric theatre and in other clinical areas. Individual concerns were promptly identified and responded to in reassuring and positive ways. Patients were spoken with in an unhurried manner and staff checked information was

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understood. When speaking on the telephone, women were encouraged to call back at any time if they continued to have concerns, however minor they perceived them to be.

## Are maternity and gynaecology services responsive?

Good



Overall, we have judged responsive as good for the maternity and gynaecology services. Refurbishments to the maternity services had been completed based on patient and staff feedback. This included the provision of a new midwife led birth unit which would provide local women a range of birth options to choose from. The bereavement facilities for maternity and gynaecology patients who experienced loss were outstanding. Sensitive, individualised care was provided to patients and their relatives. There was good flow through the maternity care pathway; however there was concern that the escalation policy was not always used to its full effect.

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

- The current and planned environmental refurbishments of the maternity services were based on patient and staff feedback. This had included refurbishment of the labour suite and parts of the ante and post-natal services.
- Systems were in place to plan maternity care to meet the needs of local people. Senior midwifery staff attended the south west strategic clinical network maternity working group. Meetings were held every two months and were attended by clinicians and managers of acute trusts in the south west region, commissioners of maternity services, patient representatives and Public Health England. The purpose of the group was to develop quality standards and benchmarking tools that took account of the needs of the local population.
- The community midwives worked with other services on local health promotion initiatives. For example, the community midwives had been trained in carbon monoxide monitoring. This was used as part of a programme to support and enable women to stop smoking during pregnancy.

- The community midwives (employed by the trust) provided care in community venues to suit individual needs. This included at patient's homes, at children's centres or at their GP practice. The delivery of care in GP surgeries provided additional opportunities to engage with local people.

### Access and flow

- The maternity services responded to the needs of pregnant women living in the locality who required care, treatment and support before, during and after birth. Between April 2014 and March 2015, 2,446 babies were delivered supported by the maternity services at Salisbury hospital. From the 1 April 2015 to 30 September 2015 there had been 954 births. Of these there were between six and nine home births per month. Between April 2014 and March 2015 2,936 women received or planned to receive ante or postnatal care by the community midwives. Some of these women chose to deliver at different hospitals.
- A range of gynaecological investigations and treatments were provided. The majority of gynaecology patients received their treatment and care on an outpatient basis. During the past three years (2013 to 2015) there had been approximately 650 emergency gynaecology admissions. Of these, 90% of patients' length of stay in the hospital was less than 24 hours. The majority (80%) of patients were treated during week days.
- A maternity triage service was provided through the maternity day assessment unit and central delivery suite 24 hours a day, all year round. This enabled pregnant women to call or visit with concerns or queries. This service supported effective flow through to the different maternity services.
- Between January 2014 and November 2015, the maternity services had not closed and were responsive to the needs of women. However, there had been occasions when the midwife to birth ratio had been excessively high. For example during September and October 2014 the ratio was 1:44, during September 2015; 1:41 and October 2015; 1:39. The Royal College of Obstetricians and Gynaecologists (RCOG, 2007) recommended a ratio of 1:28 for safe care. We reviewed the trusts maternity escalation policy. Whilst the redeploying staff to the delivery suites was used at times of high patient numbers, there was an option to close

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the delivery suite. Midwives were proud services had not ever closed. However, we were concerned as to how high the midwife to birth ratio would have to become before a decision was made to close.

## Meeting people's individual needs

- The Benson bereavement suite had been established and designed in partnership with two previous patients and their partners. These extensive facilities had been developed from charitable funds for use by patients and their relatives who were experiencing loss. This included patients who used the termination of pregnancy services. The suite was located in a separate wing off the labour suite, accessible to patients and relatives through a private entrance. This enabled other areas of the delivery suite to be avoided. The emphasis of the suite was to provide compassionate care in a home from home environment. There were three bedrooms, one with a double bed. Staff told us this enabled partners and patients to remain close and comfort each other. Other facilities included a lounge and quiet room, a private garden and kitchen area. Staff told us these additional facilities allowed extended family to visit for as long as required, including overnight.
- The maternity staff were responsive to individual needs. Patients told us staff provided personalised care and treatment. We spoke with thirteen patients and five partners. We were told staff checked with patients how they preferred to receive their care.
- Women were limited to two choices for place of delivery. Options included a home birth, or at the consultant led delivery suite (the provision of midwifery led unit was in development). Choices were dependent upon a comprehensive risk assessment of individual needs, which was regularly reviewed
- Midwives explained how they supported women with learning disabilities or women with complex or specific needs at all stages of the maternity pathway. Staff said with the woman's permission they worked closely with partners or carers and gave extended appointment times. Consideration was taken to ensure information was provided in a format the patient understood and at their own pace. This supported a reduction in anxieties.
- Each of the delivery rooms was equipped with mood lighting and a MP3 player and speakers. In addition there was a television and telephone in each room for hire.(both free). Patients' personal music choices could be played if they wished in the obstetric theatre. This enabled patients to personalise their birth experience. Each room had a recliner chair for partners to stay comfortably for extended periods. There was an infant feeding specialist who provided advice and support to patients and staff with all aspects of baby feeding. Patients were complimentary about the hospital food and told us they were offered plenty of hot and cold drinks. We observed water jugs were frequently refreshed.
- In-between set meal times, snacks and drinks were available to purchase 24 hours a day. On the postnatal ward (Beatrice) and the bereavement suite (Benson) there were kitchenette areas where women and their partners could access hot and cold drinks and snacks when required.
- Thoughtful resources were available to gynaecology patients. A large round painting, in four sections had been privately commissioned. This had been mounted on the ceiling, surrounding the main angle poised lamp and examination chair used during procedures. Senior gynaecology staff said patient feedback regarding this was consistently positive, as the painting provided comfort and distraction.
- Adaptations to the maternity environment had been completed which promoted patients' privacy and dignity. The facilities had been part of the trusts ongoing refurbishment plans. We observed windows and glass areas of doors had been covered with a patterned stencil. This blocked vision whilst maintaining light. This had been used throughout the different maternity departments.
- Translation services were available. For women whose first language was not English; information was provided in other languages. Staff said an interpreting telephone system was used regularly to support women in the hospital and community
- The senior gynaecology nurse assured us gynaecology patients' were offered, and provided with a chaperone for appointments if required.
- The trust provided a termination of pregnancy service. Information was provided on choices for fetal remains and counselling was provided as or when required.
- A range of leaflets, pictures and other information and resources were available for patients and relatives. These were related to conditions, treatments and

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medicines. These were available throughout the maternity and gynaecology departments and on the trusts website. These were also available in alternative languages.

## Learning from complaints and concerns

- Systems were in place for patients to register complaints and concerns. The patients we spoke with understood how to raise issues if they had concerns. Most patients told us they would raise issues directly with staff. The trust also provided a customer care service which was accessible in person, by telephone or email. We saw there was clear guidance on information leaflets and the trusts website. This included a suggested letter template and anticipated time scales for responses.
- Systems were in place to evaluate complaints in order to make service improvements. We looked at records which showed between January 2015 and 16 December 2015 there had been 23 concerns and complaints for the maternity service. These were reviewed by the complaints midwife and head of midwifery. We saw complaints were investigated, actions recorded and learning identified as part of clinical governance meeting minutes. Learning points were disseminated more widely during departmental meetings and the weekly staff newsletter.
- The maternity services had looked for ways to learn and make improvements from other maternity services. Senior staff were in the process of completing a service gap analysis in response to the five key learning points identified in Morecambe Bay maternity services investigation (DoH, 2015).

## Are maternity and gynaecology services well-led?

Good



Overall we considered well led as good for the maternity and gynaecology services. Thorough risk management and governance structures and processes were in place. These linked departmental and trust risk and governance meetings. This ensured an effective flow of information from ward to board and vice versa. There was evidence to

show incidents and other risk and quality measures were interrogated for service improvements and responsive actions were taken. Significant investment in the maternity services had been agreed.

Systems were in place to share information and learning. Staff were proud of the care they provided and reported senior staff as approachable and supportive. There was evidence of using patient feedback as the basis for service developments.

## Vision and strategy for this service

- There were no specific gynaecology and maternity service line strategies in place. Midwives demonstrated a broad understanding of the trusts vision and core values. All the midwives we spoke with stated their goal was to provide high quality, person centre midwifery care.
- Systems were in place to develop a unified vision and approach to maternity care across the south west region. Senior midwives attended the south west strategic clinical network, maternity working group. Meetings were facilitated every two months. The aim of these groups was to develop a cohesive approach to maternity practice across the south west area. Meeting minutes documented discussions regarding national initiatives and policies, and subsequent actions to incorporate new practice and policies at a local level.

## Governance, risk management and quality measurement

- Thorough risk management and governance structures and processes were in place. These linked departmental with trust risk and governance meetings. This ensured an effective flow of information from ward to board and vice versa. We looked at a range of departmental meeting minutes. These included the monthly maternity risk management and clinical governance meetings, and the combined maternity and paediatric risk management annual report (April 2014 to March 2015). We saw governance, risk management and quality information was recorded and subsequent actions taken. For example, following one serious incident, the actions included training for midwives and obstetricians on a new fetal surveillance programme (Perinatal

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Institutes Growth Assessment Protocol; GROW). We saw this information was shared within the maternity department, and the trusts clinical risk group though to the trust board. P

- Patient risk management and quality issues were escalated to the appropriate trust committees. A business case had been made to the finance committee for the appointment of two additional consultant posts. This was to ensure there were sufficient numbers of consultants available to provide clinical care to patients on the labour ward, and an appropriate quantity of training and support for junior medical staff.
- The supervisor of midwives (SoM) were established within the governance framework. Part of the SoMs role included investigating and challenging poor midwifery practice. We reviewed the annual audit report of standards of supervision and practice dated June 2015. This evidenced how governance systems were effective. For example, the SoMs had noted an increase in third degree perineal tears. This prompted a review of all relevant clinical cases. No themes were identified. This investigation was shared within the relevant maternity risk and governance meetings and the trusts clinical risk group.
- Effective systems and processes were in place to make quality measurements of clinical treatment and care. New audits were triggered as a consequence of enquiry or learning from incidents and complaints, and when new or updated national clinical guidance was released. The process included the completion of a baseline audit to assess the current standard. This was red, amber or green (RAG) rated. Subsequent action plans were put in place and further audit completed to measure improvements in standards. We looked at the current audit plan dated November 2015. This evidenced a number of baseline audits had been completed and identified what actions needed to be taken to improve standards. For example, compliance with NICE guidance for women with multiple pregnancy; evaluation showed 100% compliance with two of three standards. An action plan had been put in place to increase compliance with the third standard. This was kept under review and further audit was planned.
- Different systems and recording processes were used to maintain audit information which was complex. Detailed actions (including times, dates, person responsible) were recorded on the trusts governance action tracker spreadsheets. These were not readily

accessible. Summarised information was recorded at departmental levels. The risk and complaints midwives were familiar with the different systems in place. However in their absence, information was difficult to find and fully interpret.

## Leadership of service

- The consultants provided good leadership and support to junior medical staff. We spoke with junior doctors who said they had excellent support and working relationships with the consultants. The doctors told us they got the right balance of training opportunities and responsibility and they felt encouraged and nurtured by senior staff.
- Midwives told us senior staff had open door policies and were approachable and supportive. Senior midwifery and gynaecology staff were visible and present in clinical areas and demonstrated a good understanding of current clinical activity and priorities on the days of our inspection.
- The head of midwifery told us she visited other maternity services when possible. This was to review for potential service improvements. These reviews were discussed with other senior staff to assess for new service improvements at Salisbury hospital.

## Culture within the service

- All the gynaecology and maternity staff we spoke with overwhelmingly enjoyed working with their colleagues and were proud of the care they provided. Staff at all levels demonstrated a keenness for continued learning and improvement for the benefit of patient care. This was evident in how positively staff spoke regarding feedback from incidents and near misses.
- Many maternity staff felt there was a hierarchical approach between medical and midwifery staff. Whilst all staff confirmed they worked cohesively to deliver patient care, we were told this did not always extend to other working practice within the department.

## Public engagement

- Patients were encouraged to provide feedback and to complete the Friends and Family (F&F) test. Patients we spoke with told us they had been provided forms to complete prior to leaving the hospital. From October 2013 to March 2015, 1,333 maternity patients completed the F&F test. Patient feedback was consistently positive, with 1,193 'extremely likely' and 111 'likely' to



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recommend the maternity services (total 98%). The nine patients (1%) who gave negative feedback said a lack of midwifery availability was the main reason for dissatisfaction. Between April 2015 and June 2015, a further 202 F&F responses were received. The majority of these (167) stated they would be 'extremely likely' to recommend the service.

- The trusts customer care team provided a service for patient and relatives to give any feedback on care received. The ante postnatal ward (Beatrice) had been included in the trusts real time patient survey. Between April 2015 and June 2015, 472 inpatients were surveyed. When analysed, the feedback was equally divided between positive (staff attitudes) and negative comments (for maternity; how and what information was provided). We reviewed records dated September 2015 which showed action plans had been put in place to address all of this feedback. For example, one patient felt towards the end of pregnancy there was insufficient information to make a birth plan. In response all staff had been reminded of the importance of emphasising individualised care and documenting this.
- Patient feedback was used to design and develop the maternity and gynaecology services. The Benson bereavement suite was designed with full participation of previous patients and their partners. Senior staff told us the recent maternity refurbishments and design of the new department was based on patient and staff feedback. For example, the services would be based in one block in a manner to facilitate patient flow through the different services.
- The supervisors of midwives (SoMs) provided a monthly listening clinic service. This provided patients an opportunity to discuss a previous or current pregnancy if care was not provided according to birth plans. The midwives said the clinic received positive feedback and they were reviewing ways in which to provide a formal evaluation

## Staff engagement

- Systems and processes were in place to keep staff informed regarding maternity and trust updates. Staff received a weekly email update. We looked at a range of these sent to staff during August 2015 to September 2015. We observed information shared included trust and maternity specific clinical update reminders and







professional development update information from the Royal College of Midwifery. Other information relating to the trust or gynaecology and maternity services were disseminated in departmental emails and staff meetings.

- The maternity and neonatal unit staff held a joint meeting every two months. We looked at meeting minutes dated July 2015 and September 2015. These documented discussions and sharing of information related to departmental, staffing and clinical updates.

## Innovation, improvement and sustainability

- A community midwife won a Pinder award during November 2014 (Nursing Times) for her mentorship of student nurses in practice.
- There was a lack of defined future succession planning within the maternity and gynaecology services. Senior staff had expressed concern regarding service impacts in the event that key personnel retired or left their current posts. Formal succession planning was not fully established to enable new or current staff to undertake new roles and responsibility in advance of future vacancies. Formal succession planning would have minimised potential impacts of senior staff vacancies on patient treatment and care.
- The trust board had approved a capital investment in the maternity services (trust board meeting minutes dated January 2015). This was agreed based on changes to the local population as a result of army personnel based abroad returning to the local area. It was estimated this would result in an additional 100 births per year. These new developments included a midwife led birth centre. This would increase local women's choice of how and where their babies could be delivered. The work was expected to have been completed during 2016.
- The gynaecology service had identified ways to provide a more effective and responsive service to patients. This was based on analysis of emergency admissions and patient feedback. Proposals had been submitted as part of the maternity service review business case submitted to, and agreed by the board during November 2015. These included the provision of an additional nurse led scanning and assessment outpatient clinic. The aim of this was to be able to provide more timely care and enhanced patient experience.

# Services for children and young people

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

## Information about the service

Salisbury District Hospital provides service for approximately 45,000 children and young people living in and around Salisbury. Services for children are provided for a variety of clinical needs including, surgical, orthopaedic, ophthalmology, cleft palate surgery, general paediatrics, oncology, cystic fibrosis and ear, nose and throat. Surgeons employed by the trust treated adults and children within their field of specialty such as orthopaedics. Children and young people also receive medical support from paediatricians where it is appropriate.

The service is arranged on two floors of the hospital in close proximity and consists of a children and young people's unit including a ward area (Sarum Ward), a day assessment unit and a children and young people's outpatient department. The local neonatal unit is situated in a separate part of the hospital, close to the maternity unit.

Children and young people up to the age of 19 years are cared for on Sarum Ward, day assessment unit and in children's outpatients. Sarum Ward is commissioned to provide care for 16 children and young people but can accommodate up to 18 children at time of high demand in one of the ten side rooms or three bays. There is provision for a parent or carer to stay with their child. Parents are able to use the parent's kitchen, toilet facilities, shower and another larger bedroom if needed. There is a dining room for children which has a dual purpose as a school room outside of meal times.

The day assessment unit, adjacent to Sarum Ward consists of waiting areas for children and young people, a clinical room and four rooms that can be used for assessment of a child or young person's condition. The children and young person's outpatients department is on the floor below the ward area with waiting areas for children and families and a variety of rooms used by therapists, doctors and nurses. Each of the two floors has a secure outside play space that is accessible to patients and their families.

Neonatal Unit (NNU) has four bays that can accommodate 14 babies. Parents can use the single and double rooms as well as the toileting facilities and parents kitchen and lounge areas on the unit.

There are other hospital departments that care for adults as well as children and young people. These include radiology, sexual health, day surgery unit, bereavement suite, burns unit, theatres and general outpatients.

Day surgery unit is in a separate part of the hospital. It is arranged in three bays with one side room and is used for adults and children with curtains to screen children from viewing adult care if needed. The unit has its own surgical theatres and recovery areas arranged on two floors.

Sexual health offers clinic appointments offering advice, testing and treatment to young people and adults. The clinic area is within the hospital grounds. The service also runs ten clinics outside of the hospital, across the county of Wiltshire.

During our visit we spoke with 64 staff members which included consultants, medical staff, nurses, managers and support staff. We also spoke with 18 parents, nine children

# Services for children and young people

and young people. We visited the paediatric areas as well as facilities which children and young people shared with adult services. In all areas we observed care and reviewed care records and other documents.

Salisbury Hospital admitted 1,819 children and young people to the children's unit between January and December 2014. Of these 2% were day cases, 19% were elective and 79% were emergency admissions.

## Summary of findings

Overall we found the services for children and young people to require improvement.

Staff were clear they wanted to provide the best care they could for children and young people but there was no clear vision for how the service wanted to be performing in the coming years. The recent successful tender for children and young people's community services by another provider was having an effect on forward planning in the acute service.

Staffing levels for both medical and nursing staff did not meet the nationally recommended guidelines for the acuity of children cared for in the hospital. Risks to patient safety regarding nurse staffing levels had been raised as a concern but no permanent arrangement had been put into place to maintain safe staffing levels. High dependency patients were nursed on the ward but there was no funding available within the baseline budget for the extra nursing staff needed to care for these patients.

Safeguarding training did not meet national guidelines at the time of our visit but we were shown a plan was in place to provide this training and a timeline for meeting the guidelines.

There were times when children and young people were cared for in areas used for adults such as some outpatient appointments, main theatre and day surgery unit. Some provision had been made to protect children from adults in these shared areas. We found the screens to protect a child were not always used.

Learning from examples of past practice was encouraged and medical staff felt well supported by their senior colleagues. Staff were able to access training that would add to their skills and the majority of nurses in the neonatal unit were trained in their specialty. Children and young people's needs were cared for and responded to by competent staff. Policies and protocols were based on national guidelines ensuring that best practise was observed. Audit programmes were contributed to both internally and nationally to demonstrate how well the department performed against other trusts.

# Services for children and young people

All staff worked flexibly to support the needs of children, young people and their families. Staff worked together and shared information appropriately with community staff to ensure the safety and wellbeing of children who were being discharged home.

Staff were compassionate in their treatment of patients and their families and privacy and dignity was respected at all times. Children and young people's views were listened to and their consent was always sought in a way they could understand. Facilities were provided and used flexibly for parents to spend time with their children and at times included the accommodation for the patient's whole family.

Staff had developed methods of gaining feedback from children of all ages and had made changes to facilities in response. Patient and parent feedback we saw was positive with comments including "unconditional support and care", "cheerful, even at the end of a long shift" and "patience and honesty".

Staff from the children's unit were supporting those areas where adults were also nursed with projects designed to improve a child or young person's experience when they visited that area.

## Are services for children and young people safe?

Requires improvement



We rated services for children and young people as requiring improvement for safety.

All areas were aware of the 2013 RCN guidance for safer staffing but these were not always observed to be followed. Areas did not all use an established method of calculating how many staff were required to care for their patients. Where this was used the indicated staffing requirements were not always in place which left children at risk. On one occasion, after we raised a concern with the senior management team about inadequate staff numbers presenting a risk to the safety of children, extra staff were provided.

Medical staffing did not comply with guidelines from the British Association for Perinatal Medicine. To mitigate the lower numbers of junior medical staff, consultants provided a greater level of cover out of hours.

Not all areas we visited used a tool for early recognition of when a baby's condition was deteriorating. As mitigation the majority of nursing staff in the neonatal unit had additional qualifications in their specialty providing them with knowledge and skills to recognise what action was needed when a patient's condition was deteriorating.

Staff compliance with mandatory training was variable and did not always meet the trust target of 85%. Level three safeguarding children training had not been completed by all staff working with children. There was a programme in place to provide more opportunities for staff to access this training.

Not all areas of the hospital had rigorous, documented cleaning systems for toys held in their department. Neonatal unit (NNU) had equipment that had been cleaned but nothing attached to identify how long ago it had been cleaned. We were subsequently told there was a daily cleaning log which included equipment in use and in storage. The areas we visited looked clean and audits showed there were no concerns regarding hygiene. If an infection was identified appropriate actions were taken.

# Services for children and young people

Staff followed the trust policy for transferring children in need of alternative care and kept children safe.

Senior medical staff were always available to support the care of children and advise more junior colleagues.

## Incidents

- Staff understand their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them.
- Never events are largely preventable patient safety incidents that should not occur if preventative measures are taken. There was one recorded never event involving a child which occurred in September 2014. This event was fully investigated by the trust and an action plan of changes to procedures in surgical theatres was identified. There had been no further untoward events or incidents recorded between that time and December 2015.
- Staff in all areas of the children and young people's service were confident in using the electronic reporting system. We were told of occasions it had been used to report concerns, risks or near misses. Two of the staff we spoke with told us of how they could access feedback regarding the outcomes from their reporting. However another two staff informed us they had received no feedback from incidents they had reported although they were aware feedback was available.
- Mortality and morbidity meetings were held for babies in the perinatal period to review circumstances and learning points of serious illness and death in neonates. The records we saw of these meetings showed discussions between a range of professionals about the outcomes of clinical interventions. Concerns around serious illness and death in older children were discussed at the multi-agency child death and overview panel meetings. These meetings were attended by a paediatrician from the trust and learning was shared at staff meetings. There were also 'sick kids' meetings which had been developed by a paediatric consultant to discuss and share learning on treating medical conditions in children and young people more effectively. Minutes from the November 2015 meeting showed attendance of medical staff from intensive care, anaesthetists and registrars. Information from these meetings was shared with staff at team meetings.
- Duty of Candour legislation has been in place since November 2014 and requires an organisation to disclose

and investigate mistakes and offer an apology if the mistake results in a death, severe or moderate level of harm. We saw records where families had been informed about a mistake that had been made and an apology offered. Staff we spoke with were aware of the term duty of candour, told us that training was available and described how they were open and honest with patients and families.

## Cleanliness, infection control and hygiene

- Infection prevention and control procedures were in place and seemed to be practised by all staff we observed.
- Hand sanitiser, with instructions for use, was available for staff, patients and visitors to use on entry to the ward and at other strategic points on any unit we visited. We observed staff complying with the trust infection prevention and control policy by ensuring they were bare below the elbow, hands were sanitised on entry to a ward area and before and after patient contact. Where it was necessary to protect patients from the spread of infection, protective equipment such as gloves and aprons was available and used appropriately.
- Audits were undertaken monthly to measure how well the children and young people's service were managing the prevention and control of infection. For the period between April and August 2015, the monthly hand hygiene audit reported compliance to be between 92% and 100% on Sarum Ward and at 100% for outpatients, sexual health and neonatal unit. The trust had a target of 95% compliance. The results identified compliance of each professional group; nurses, doctors, allied health professionals and other. The August result showed that out of two people observed in 'other' group, one was not compliant with hand hygiene procedures and could not be identified from the documentation to remind them of good practice. Sarum Ward, children's outpatients and day assessment unit achieved 100% compliance in the hand hygiene audit for July and August 2015.
- Information about safety of the patients on Sarum Ward was displayed for visitors to see. It displayed information about the number of infections on the ward and hand hygiene audit results
- There was no recorded incidence of *Clostridium difficile* on any of the children's units for the period between June and December 2015. Blood cultures results had shown the presence of methicillin-resistant



# Services for children and young people

staphylococcus aureus (MRSA) in a child admitted to Sarum Ward in August 2015. Appropriate action had been taken to reduce the spread of infection and investigate any additional actions required by the trust. This included keeping the child in a single room with private washing facilities and staff wearing protective equipment when they entered the room. NNU reported an incidence of Staphylococcus aureus following which all staff used a course of antibacterial lotions on their skin to reduce the risk of spreading infection.

- Equipment we saw on Sarum Ward looked clean and had 'I am clean' stickers identifying when it had last been cleaned and that it was ready for use. The neonatal unit had covers over equipment that had been cleaned but no date identifying when the cleaning had taken place. Cleaning of toys in the children's ward and outpatients department were included in the housekeepers' task list and the senior nurse on duty would sign a record to confirm the cleaning had taken place. Cleaning of toys that were in other areas of the hospital where children might visit were the responsibility of that area. For example, theatres had a small box of toys for young children which we were informed were cleaned with a sanitising liquid on a weekly basis. There was no record of when this cleaning had taken place and therefore no evidence that the toys had been cleaned.
- Mothers were able to express breast milk and store it safely in a fridge or freezer for future use. Both NNU and Sarum Ward had a process of checking the correct milk was being used. NNU's process was for mother to label the breast milk with babies name and date expressed and stored on a tray dedicated to that baby. Before use it was checked by two nurses. Sarum Ward would store breast milk labelled with the child's first name, date of birth and date milk was expressed. Before use it was checked by mother and a nurse.
- Salisbury hospital scored higher than other hospitals in England in the CQC children and young people's survey 2014 which asked adults how clean they thought the hospital area was that their child was in. Results from the 2015 survey were not available at the time of our inspection.

## Environment and equipment

- The environment was suitable to care for children and young people. Processes were in place to maintain safety of equipment and action taken when faults were found.
- Sarum Ward had ten side rooms, five of which had private toileting facilities, two bays of two beds each and one bay of four beds. Each of the bays had access to their own toilet and shower. There were additional washing facilities and equipment to help patients with mobility difficulties. A room was dedicated for parents to prepare bottle feeds and store expressed breast milk safely. The milk fridge had a process for checking that a safe temperature was maintained and guidelines were attached to the fridge. We saw two occasions where the temperature had not been documented as having been checked. Staff were made aware of the lack of documentation
- Sarum Ward, day assessment unit and NNU were accessible by a system where staff released the door for visitors to enter. When leaving Sarum Ward area visitors would press a door release button placed too high for young children to reach. Visitors leaving NNU would need the door to be released by a member of staff. The main doors were monitored by closed circuit television which also monitored children's outpatient department on the floor below. Children's outpatients' main door had no locking system but the reception desk adjacent to the door was staffed when the department was in operation.
- NNU was arranged in four bays with accommodation for 14 cots which were all visible to nursing staff through glass panels. A fridge and freezer were available for storing expressed breast milk. The temperature checks were completed and documented appropriately.
- Paediatric resuscitation equipment was available to use in all areas where children and young people were cared for. There was a system to record that appropriate regular checks were made to ensure it was available and safe to use. The burns unit had an incidence of two dates in November 2015 when the record had not been signed to verify the resuscitation equipment had been checked. This was brought to the attention of staff on the unit at the time of our visit.
- In all areas we visited equipment had been serviced to ensure it was safe and ready to use. The date of the recommended next service date was attached to the equipment.

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- Storage areas for clinical waste were uncluttered and waste was removed regularly without risk to children or young people.
- There was a vacuum system of sending specimens to the laboratory for testing. Staff placed the specimen in a tube on the ward and did not need to leave the ward.
- Fridges were available for medicine storage on Sarum Ward and NNU. There were systems in place to check that temperatures were maintained at a safe level and procedures for reporting when temperatures were noted to be outside of the safe level.

## Medicines

- Processes were in place to ensure medicines were stored and administered safely.
- A pharmacist with paediatric knowledge visited Sarum Ward, NNU and burns unit daily from Monday to Friday. We saw charts had been signed by the pharmacist as being compliant with trust policy. Staff also told us the regular visits from the pharmacist meant advice was available around prescribing issues or other medicine queries reducing the incidence of prescribing errors.
- In all the areas we visited we found medicines were stored securely in locked rooms. Controlled medicines were stored in a separate locked cabinet in a locked room. They were checked daily by two qualified staff members who signed a log to verify the check had been completed. Stock levels were also checked by a member of the pharmacy team.
- Intravenous fluids, medicines and oral medicines were stored and prepared in an area away from access by children young people and visitors.
- Sarum Ward had reported a fridge not working adequately for medicine storage. As a result they had relocated the medicines to another fridge in the intravenous preparation room and were waiting for delivery of a replacement fridge.
- Pharmacy staff undertook audits of storage facilities and their correct use on each area. We saw the audit for NNU in August 2015, identifying action needed to maintain a medicines storage room at a lower temperature. Recommendations were recorded and followed up by being reported on the electronic reporting system and ongoing monitoring of temperatures.
- Compliance with the trust antibiotic prescribing protocol was audited on Sarum Ward in August 2015. The result was 93% compliance which exceeded the trust target of above 80%.

- Paper medicine charts were being used and were clearly written with allergies, child's weight and age documented. Of 14 charts we examined two had no documentation of a prescribed intravenous saline flush and the remaining 12 were completed accurately.
- There were three incidents regarding medicine errors on Sarum Ward for July and August 2015. These had been reported, investigations held actions taken to reduce the risk of repeating the error.

## Records

- There were systems and processes in place to ensure the confidentiality of patients' records. Paper patient records were stored in locked trolleys with a key on Sarum Ward which was stored at the nurse's station for staff to access. NNU used a number combination lock for staff to access the notes storage trolley.
- Charts used for monitoring a child or young person's condition and nursing needs such as fluid recording and observation charts were kept at the end of each bed or cot and outside the single rooms. This meant they were available immediately for staff to view the needs of the patient.
- Clinical records which reviewed a patient's condition and held test results were kept in the locked trolley on the ward. These records were updated by all staff involved with the child including nurses, allied health professionals and doctors. All records we saw had a record of the history of the child or young person, social circumstances and clinical condition on admission to the hospital. They were reviewed by senior clinicians and had a plan for ongoing care needs.

## Safeguarding

- The trust had a team with responsibility for safeguarding children consisting of named professionals. This team included representation to the trust board, a medical lead, a named nurse and nurses in areas such as sexual health, paediatric ward and maternity unit who acted as champions for safeguarding children
- The trust had a system of finding out if there were any safeguarding concerns about any children in the hospital and placing an alert on the child's electronic record for staff to see. Staff confirmed they were alerted to concerns in this way. Trust staff we spoke with informed us they followed the safeguarding children protocol about reporting safeguarding concerns to social services. Paediatricians would refer any child

# Services for children and young people

protection concerns as they would undertake a medical examination as part of the referral process but if they were not available nursing staff would log a concern. We were told of a time within the last month, when nurses had contacted social services to check whether a family were known to them.

- Trust policy stated “To be compliant with the Children Act: Section 11, all staff should receive suitable training, commensurate with their needs as identified in Working Together to Safeguard Children (2015)” The named nurse for safeguarding had completed a training needs analysis in May 2015 which identified staff compliance with different levels of safeguarding training. We were unable to isolate the compliance figures for staff in contact with children but results for the trust as a whole, in September 2015 showed:
  - 83% compliance for level one training
  - 75% compliance for level two training.
  - 21% compliance for level three training (this figure had risen to 41% compliance in November 2015)

Compliance with level three safeguarding training was calculated for those staff groups needing to complete it. The intercollegiate document - Safeguarding children and young people: roles and competences for health care staff, March 2014 states “All clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns”. This training needs analysis demonstrated a strategy for increasing staff compliance with level three safeguarding training to 90% by 31 March 2017. This trajectory had been agreed with the clinical commissioning group for the trust.

All the staff we spoke with told us they had completed level one and two safeguarding training. The training package we saw had been approved by Swindon and Wiltshire Local Safeguarding Board and included information on female genital mutilation with supporting guidance available from the trust’s sexual health department.

The ward manager of Sarum Ward kept a record of which staff had completed level three safeguarding children training which at the time of our visit was at 80%. There was a system of cascading safeguarding supervision. Lead nurses would attend a two day supervision course after which they would be able to offer safeguarding children

supervision to their teams. The named nurse for safeguarding would supervise these lead nurses. All staff we spoke with said the named nurse for safeguarding was available and supportive and were able to contact her if they had any concerns.

- Staff with the sexual health department undertook training for their specialty, such as child sexual exploitation and domestic abuse. Since October 2015 this had included training on female genital mutilation.
- Security in children’s areas complied with the trust abduction policy. Main doors to NNU were operated by staff for both entry and exit. On Sarum Ward main doors were operated by staff on entry only and visitors could let themselves out by using a door release button. This was placed too high for a small child to operate and the area was overseen by closed circuit television screens on the ward. Between 8am and 6.30pm a receptionist was present at a desk with clear view of the doors.
- All patient records we saw had the section about involvement of other services including social worker, completed appropriately. Nurses on day surgery unit and paediatrics had a system to inform community public health nurses of any concerns that may need following up after the patient was discharged. An example of this was when children had dental extractions which may have been indicative of neglect.

## Mandatory training

- The trust had a programme of training that all staff needed to attend identified on a mandatory training matrix which included the required frequency of updating knowledge. This included training in moving and handling, fire safety, infection prevention and control and fire safety. Other programmes were identified for specific staff roles that needed completion and included paediatric immediate life support which needed to be completed by doctors, operating department practitioners, registered nurses, registered nurses for children and midwives. Staff told us they were made aware of the training that was due to be completed on receipt of an e mail generated by the electronic learning system.
- Levels of staff compliance with mandatory training were measured by the trust but were presented as directorates. Children and young people’s services were part of the clinical support and family services directorate. Other areas that were part of this directorate

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were maternity and gynaecology, neonatal unit and children's therapy services. The trust target for compliance with mandatory training was 85%. Staff compliance within the directorate ranged between 66% for mental capacity training and 88% having completed health and safety training. Ward managers informed us that all staff working with children had undertaken paediatric life support training appropriate for the age of child in their care.

## Assessing and responding to patient risk

- Each child or young person had a paediatric nursing assessment completed on admission. It included risk assessments based on the condition and medical history of the patient with any special needs or safeguarding issues documented. Burns unit had a risk assessment tool which was specific to the degree of burns experienced by the child. Sarum Ward and burns unit used age specific Paediatric Early Warning Score (PEWS) charts which were kept at the end of the child or young person's bed or outside their single room. Escalation advice was included on the PEWS for the actions that nursing staff should take if a child's condition deteriorated. The observation charts had been completed consistently. Staff compliance with completing the PEWS had not been audited for the previous 12 months. Senior staff told us this was because the tool was being reviewed and developed in conjunction with the regional Paediatric Critical Care Network and would be audited once the revised tool was in place. We saw records where a paediatric sepsis screening tool was used. This included advice for the risk a child or young person may be suffering an infection and appropriate actions health professionals should take.
- Nurses on NNU used other charts to record risk. Their additional training in their specialty gave them the knowledge and skills to recognise when to escalate a child's deteriorating condition. We were told of plans to introduce an early warning score chart for neonates in the near future but this was not in place at the time of our visit. These early warning score charts were being trialled for babies identified as at risk but not routinely for all babies in NNU. An example given was a baby may be identified as at a greater risk of acquiring a group B streptococcal infection. Other babies had their clinical observations recorded on a special care observation

chart which were completed appropriately recording when a possible deteriorating condition needed escalating. We did not observe any early warning score charts being used at the time of our visit.

- Should a child or young person have needed to be ventilated to support breathing for more than 48 hours policy was that arrangements would be made to transfer the child to a more specialised unit. We saw the transfer procedure taking place when a poorly child was transferred by a specialist team to a unit providing more specialist intensive care. The paediatrician had arranged the transfer soon after the child had been admitted to the ward. A full history of treatment was communicated to the specialist team and parents were kept informed.
- Side rooms near the Sarum Ward nurses station were used for patients with high clinical dependency. We were told by paediatricians there was potential for three high dependency children to be cared for on the ward although this level of service had not been funded by commissioners. We saw an occasion when the lack of nursing staff had resulted in a child who needed high dependency level care had no direct nurse observation leaving the parent to observe and call for help if needed.
- Where children and young people had surgery we saw the World Health Organisation surgical safety checklist completed appropriately. Audits of compliance with using this checklist were undertaken for all ages of patients attending for surgery. It was not possible to separate the data that applied to children and young people.

## Nursing staffing

- A lack of nursing staff compromised patient safety when children and young people needed a higher level of nursing input.
- Planned and actual staffing levels for Sarum and NNU were monitored by the trust and bank nurses were used to fill any unexpected staff absences or extra needs of higher dependency patients. Nursing staff told us that if bank nurses could not be found, nurses may be redeployed from another area such as NNU or staff from the ward would work extra hours. There was a reluctance to use staff supplied by other agencies as they would be unfamiliar with the ward and perception by staff that it would incur additional financial expense. The average rate of actual staffing levels meeting the planned staffing levels on all shifts in November 2015 was;

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- Registered nursing staff
  - Between 93% and 97% for NNU
  - Between 96.8% and 103% for Sarum Ward
- Healthcare assistants or nursery nurses
  - Between 13% and 52.5% for NNU
  - Between 87% and 175% for Sarum Ward

These planned staffing levels did not always meet those recommended by the 2013 RCN guidance on safer staffing for paediatrics. This resulted in the planned staffing levels being met but paediatric areas remaining understaffed for the acuity of patients they were caring for.

- NNU had no acuity tool in place to plan required staffing levels but used the British Association of Perinatal Medicine (BAPM) standards as a guideline. Staff informed us the cots were rarely occupied to full capacity but that a workforce review was in progress using a benchmark of 70% occupancy of the cots. This had indicated a need for four registered nurses (child) and a health care assistant or nursery nurse to be on each shift to comply with (BAPM) standards. The staffing rota for the previous four weeks had shown staffing levels to range between two and four registered nurses per shift. A recent concern about staffing had been raised using the electronic reporting system. Senior nursing staff told us that by the end of January 2016, they anticipated having three registered nurses and one health care assistant rostered on each shift. The increased staffing levels followed recent recruitment of staff who were working their notice period and awaiting their disclosure and barring system checks.
- The Sarum Ward manager had responsibility for ensuring that day assessment unit, Sarum Ward and children's outpatients were staffed with appropriately trained nurses. Skill mix reviews were carried out by the ward manager six monthly. Staffing risks for Sarum Ward were raised at the trust board meeting in August 2015. An acuity tool was being trialled by Sarum Ward manager and risks highlighted to senior managers as they occurred. Insufficient staffing had been an item on the trust risk register in January 2015 and again in June 2015 and reported to clinical governance meetings in 2014 and 2015. Each registered nurse on the day shift would be caring for five patients as an average with fluctuations during the day as children were admitted and discharged. These children could be of any age. The 2013 RCN guidance on safer staffing for paediatrics recommends a minimum ratio of one registered nurse

to three patients who are under two years of age, one nurse to four patients over two years of age and for high dependency patients, one nurse to two patients. In addition there should be a band seven registered nurse to work on a supervisory level. There was potential and capacity for three high dependency patients and 15 other patients needing to be cared for on the ward. The senior nursing staff told us they most often worked clinically when their role should have been supervisory. The night nursing complement had been re arranged using the existing ward budget, from two registered nurses with a health care assistant to three registered nurses with no health care assistant. This was reported to the trust board as increasing safety for patients at night. Staff told us the flexibility of having an extra registered nurse at night had improved patient safety.

- At the time of our visit we saw a high dependency patient in a side room with no direct registered nursing supervision as the nurse had been called away to attend to other patients, leaving the parent to use the emergency buzzer if there were any deterioration in the child's condition. When this was raised with the directorate manager as a risk to patient safety, a registered nurse (child branch) was redeployed from the NNU to work on Sarum Ward. No acuity tool was formally in place to assess staffing needs but the ward manager had researched and was trialling an acuity tool to provide this information. For the period between 09 November and 30 November 2015 using this acuity tool, the staffing hours provided had not reached the hours that had been assessed as needed. The understaffing ranged from a period of 20 minutes to over five hours per day for that period. At an unannounced visit on 13 December 2015, Sarum Ward staff told us there had been a risk meeting the previous week resulting in an extra registered nurse on duty for each day shift and if required, there had been another registered nurse allocated for the night shift. There was no extra registered nurse at the time of this visit but all avenues had been explored to provide the extra nurse with no success. Ward staff told us they were managing the needs of the patients on the ward at this time.
- Day assessment unit was staffed with two registered nurses (child branch). Sarum Ward and day assessment unit would support each other when they were able.
- We observed staff handover where clinical needs of patients were discussed and nurses consulted and updated parents at the bedside



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- Children's outpatients was staffed by a health care assistant and reception staff. Consultants, registered nurses and therapists were in attendance when they were holding their clinics.
- There was one registered nurse (adult and child branch) on the burns unit who would prioritise the care of children when they were admitted to the ward. Staff from Sarum Ward also supported care of children who were patients on the burns unit. If neither of these options were possible children would have a registered nurse (adult) who had completed additional competencies with children, assigned to their care. The senior ward staff of burns and Sarum were working together investigating methods of ensuring RCN guidelines for staffing were met and that children were cared for by appropriately trained nurses.
- Day surgery unit was an area used for adults and children. Due to staff turnover the number of paediatric trained nurses on the unit would be reducing in the near future. The paediatric nurses were unaware of any action plan to address concerns that remaining paediatric nursing staff would be unable to cover every shift children were in the department. However, this had only been raised with managers within the previous week.

## Medical staffing

- Sufficient numbers of medical staff were not always available within the hospital but an on call system was developed to mitigate any risk to patients. In September 2014 the proportion of paediatric consultants employed by the trust was 15% higher than the England average with 6% fewer registrars and 2% fewer junior doctors. Day time shifts were adequately covered with all grades of medical staff. The weekend and night time on call rota was provided by a consultant being on call, a registrar or consultant resident in the hospital and one junior doctor present in the hospital. This provided medical care for children in two areas of the hospital at any one time such as, Sarum Ward and NNU. If paediatric medical assistance was needed elsewhere in the hospital such as the emergency department or maternity unit the on call consultant would attend. The British Association of Perinatal Medicine (BAPM) guidelines state that in a hospital where there is a Local Neonatal Unit, there should be two junior doctors present at all times. The trust were aware they did not meet these guidelines at evenings and weekends and

had developed a system where consultants were available to cover any shortfall. Use of locum medical staff for children and young people services was very low. The highest rate we saw was 0.7% for the month of September.

- There was a daily consultant round on Sarum and NNU and handovers involved all grades of medical staff and discussed needs of the children. This was followed by a visit to each child on the ward and discussion with parents. Patient records showed compliance with The Royal College of Paediatrics and Child Health (RCPCH) guidelines with no child admitted having waited longer than 24 hours to see a consultant.

## Major incident awareness and training

- Plans had been made to cope with an increased demand in the winter by increasing Sarum Ward bed capacity to 18 and opening day assessment unit at weekends.
- Staff we spoke with were aware of their roles in the event of a major incident and knew how to access the policy. One member of staff we spoke with said they did not know of a major incident policy and would expect to be informed of expected actions by managers.

## Are services for children and young people effective?

Good



We rated services for children and young people as good for delivering effective services.

Staff took measures to make sure that children and young people were cared for appropriately. They complied with trust recommendations and guidelines wherever they could and contributed to local and national audit programmes.

Policies and procedures were based on nationally developed guidelines and were accessible for staff.

Staff involved specialists to support effective care for children and young people. Dieticians were available to support nutrition and hydration, psychological and mental health services worked with all areas we visited. Regional networks were used to support specialist practice such as burns and neonatal services.

# Services for children and young people

There was communication between staff internally and outside the hospital to support the ongoing care of children and young people. Patients living with long term conditions were supported to learn about how to manage their conditions using a variety of methods and organisations outside of the trust.

Pain that children and young people were experiencing was well controlled with regular pain relief given where it was needed.

Staff competency was monitored with opportunities offered to continue their learning and obtain additional skills.

Children, young people and their parents or carers were encouraged to be involved in decisions about their care with people of all abilities being communicated with in a way they could understand.

## Evidence-based care and treatment

- The children and young people's service promoted good quality care based on available evidence.
- Policies, procedures and guidelines were available to staff on the trust's intranet such as for the management of acute asthma, sepsis and bronchiolitis. These were based on guidelines developed by specialist bodies for these conditions including those from National Institute for Health and Care Excellence (NICE). Some of the more commonly used policies were also available in paper copy which posed a risk that staff may not be referring to the most up to date guidance. We saw an occasion where the electronic held guidelines from the British Society of Paediatrics Endocrinology and Diabetes was from 2013 and the paper version was from 2009.
- Specialist nurses were supported in their practice by linking with specialist centres for conditions such as cystic fibrosis, oncology and palliative care. A transition programme was provided for young people with long term conditions moving into adult care. This programme which followed NICE guidelines had been shown to be effective in other areas.
- NNU actively encouraged skin to skin care between babies and parents (an established method of promoting bonding, lowering stress levels and optimising brain development in babies) with leaflets

and physical support where needed. There were single bedded rooms designed for this purpose called 'kangaroo rooms'. We saw staff supporting parents who were engaging with skin to skin care with their baby.

- The sexual health department had policies in place based on national guidelines and audits were undertaken to assess compliance with standards, such as compliance with NICE guidance on standards for administering long acting reversible contraception.
- Children and young people had care plans available for use and records we saw were completed according to trust policy.

## Pain relief

- Nurses assessed children's pain by using age appropriate assessment tools such as smiley faces and numbers to grade pain. These assessment tools helped children of all abilities to communicate how much pain they were in and were included in every child's nursing record. Children and young people we spoke with told us they had been offered pain relief.
- The CQC children and young people's survey 2014 showed that parents thought Salisbury hospital staff were better than other hospitals in England for doing everything they could to ease their child's pain.

## Nutrition and hydration

- Suitable and sufficient food and drinks were available to maintain patients' nutrition and hydration. Staff had access to dietician advice if they needed it and were able to offer mid-morning and mid-afternoon snacks for children who preferred to eat smaller portions more frequently. A children's menu offered a variety of foods to encourage children to maintain their nutrition such as pizzas, smaller snacks and pureed food for those undergoing surgery to the mouth. Food was checked before serving to ensure it was at the appropriate temperature to be safe for consumption.
- Drinks such as cordial and fruit juices were always available for children on Sarum Ward.
- Breast feeding mothers were able to store expressed breast milk and store it safely for future use.
- Patient records we reviewed showed that any fluid or dietary intake was monitored and recorded where necessary.

## Patient outcomes

# Services for children and young people

- Between February 2014 and January 2015 the number of emergency readmissions following elective surgery at Salisbury hospital was 2.8% which was below (better than) the England average of 3.8% for children less than one year old. Readmissions for children between one year and 17 years of age following elective surgery was 1.4% which was also below the England average of 2.7%. Readmissions following emergency treatment for the same period were very low with actual numbers not being reported to protect confidentiality of the patient.
- Paediatric diabetes audit performance for 2013/14 published October 2014 indicated the trust performed at a similar level to the average for England.
- NNU contributed to the National Neonatal Audit Report. The results for 2014 which were published in November 2015 showed the trust met or exceeded the national standard for three of the measures:
  - A documented consultation with parents by a senior member of the neonatal team within 24 hours of admission
  - Retinopathy of prematurity screening in babies with a gestational age of less than 32+0 weeks or greater than 1501g at birth
  - All babies above or below 28+6 weeks gestation had their temperature taken within the first hour after birth
  - The trust had not reported on the data at the time of our visit but had shown improvement in two of the measures compared with the previous year's results.
- The sexual health department audited their service according to the standards set by The British Association for HIV and Sexual Health (BASHH) and Medical Standards for the management of STIs (MedFASH). Results of the audit dated January 2014 rated them as compliant with all standards.
- A practice educator was supporting burns unit and Sarum Ward with developing competencies for adult nurses in caring for children. This was being supported by a local university for nursing education to ensure it was valid.
- Student nurses were supplied with information on Sarum Ward as an induction programme and staff were being developed as mentors to support the student nurse programme. Staff told us they had no problems accessing further training to extend their skills. Sarum Ward held team meetings three times a year which supported staff development and included updates on clinical procedures.
- Outreach nurses had extra qualification in their specialty such as cystic fibrosis and oncology. Specialist nurses worked with regional networks to support and update their own practice and shared updates and training with paediatric ward staff.
- All staff we spoke with were aware of the procedures for appraisals and said they were notified when these were due by an e mail from the electronic tracking system. Supervision was led by managers of the units with one to one meetings being held.
- Revalidation for consultants was linked to the appraisal process. The responsible officer ensured revalidation of medical staff was up to date. Medical staff told us they had job plans and the ones we saw were appropriate for the grade. Appraisal rates were measured as a directorate and not isolated to the clinical areas. The completed appraisal rate for April to September 2015 was 66% for non-medical staff and 82% for medical staff. The ward manager kept a record of staff appraisal rates and told us 75% of Sarum Ward staff were up to date with their appraisals.
- Medical handovers and ward rounds included a teaching element so that more junior staff were supported in ongoing learning. Training times were also offered for medical staff on a monthly basis.
- All staff caring for children in recovery areas had completed paediatric immediate life support modules. Consultants had completed Advanced paediatric life support training. Ward managers informed us that all nursing staff working with children had undertaken paediatric life support training. The data was not available to view.
- Consultant anaesthetists were trained in children's anaesthesiology and would be available when children were undergoing surgery.

## Competent staff

- Processes were in place to ensure staff were competent to care for children and young people.
- There were 22 registered nurses on NNU of whom 18 were qualified in their specialty and two others were in the process of completing this additional training.
- NNU had competencies that staff needed to complete before undertaking procedures, for example competencies for taking neonatal blood pressures.

# Services for children and young people

- The pharmacy department delivered training for new medical staff on prescribing for children.

## Multidisciplinary working

- Ward and department staff worked with a range of other professionals to ensure a multi-disciplinary approach to care and treatment. We saw examples of multidisciplinary team working in the areas we visited. We were told of close working relationships with other health professionals, physiotherapists, school staff, occupational therapists as well as contacts with health visitors and social workers.
- Pharmacists who had completed paediatric competencies supported areas where children were cared for. They visited Sarum Ward, NNU and burns unit daily to support the supply of appropriate medicines for children and were able to offer specialist advice to staff who were writing prescriptions.
- Child and adolescent mental health services (CAMHS) which were provided by another NHS organisation contacted Sarum Ward daily and would visit the same day if a child needed an assessment.
- A play specialist was available from Monday to Friday to support children and young people who were anxious or distressed. Toys were used to help a child to understand a procedure. This support was offered to any child in the hospital if it was needed.
- Transition services were being developed for children with long term conditions that would require ongoing support from adult services. A programme of support was being offered by paediatric and adult diabetic specialists for diabetic children between the ages of 12 and 19 years old. Specialist staff were working with a local supermarket and offering cookery courses for diabetic children and their families.
- Discharges were discussed at ward rounds and parents were kept updated by nursing and medical staff. GPs were informed of discharge either electronically or by letter. Other professionals would be contacted by phone or by letter depending upon the need for follow up care. The day assessment unit could be used for more urgent follow up of discharged patients. We saw a child who had been contacted to return the day following discharge for further tests.
- The CQC children and young people's survey 2014 showed that parents thought Salisbury hospital staff were better than other hospitals in England for working well together.

## Seven-day services

- Radiology and diagnostic imaging services were available for children and young people seven days a week.
- Consultants reviewed their patients daily seven days a week. A paediatric consultant was resident at the hospital on an on call basis at weekends and evenings for advice, support and treatment.
- Out of hours paediatric pharmacy support was available for children's services from pharmacists who had gained extra knowledge specific to children.

## Access to information

- Staff across the children's service were able to access information in a timely way. Information for GPs was made available through discharge processes.
- GPs were given a summary of a child's admission and informed of their discharge from hospital. The information was sent either electronically or in paper copy if the GP did not share the secure information sharing system. We saw a discharge letter which had been recorded as having been sent electronically within two hours of the patient's discharge.
- GPs could refer patients to the children and young people's day assessment unit for further specialist opinion.
- Children's oncology service used parent held records which were updated by staff each time the child was seen.
- The children's outpatient department had a system to ensure records were available for the child or young person's attendance. Staff we spoke with told us they had not experienced any difficulties in accessing records.

## Consent

- Staff demonstrated the use of Gillick competency principles (used to help assess whether a child or young person has the maturity to make their own decisions and to understand the implications) when assessing people's ability to consent to procedures. We witnessed nurses involving children and young people in making decisions about their care and treatment and using terminology the child could understand.
- Consent was obtained by staff from children and young people and if they were too young or unable to legally consent for themselves, parents or carers would be

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asked for their signed consent. Parents told us children were spoken to in a way they could understand especially if their understanding was below the average for their chronological age such as children with learning disabilities.

- We were told by staff of how children's decisions were respected and every effort was made to support the child's wishes.
- We saw records of how staff in sexual health supported patients with learning disabilities to enable them to access treatment they needed appropriately.

## Are services for children and young people caring?

Good



We rated the children's and young people's services as good for caring.

Feedback from children and young people who used the service and their families was positive with quotes of "kindness", "staff were always cheerful even at the end of a long shift", "unconditional support" and "patience".

Time was always given for patients and families to ask questions. We saw how staff talked with patients and their families in a way they could understand and were empowered to make their own decisions. We saw how staff talked together to ensure parents had a consistent message from professionals.

Facilities were used flexibly to provide privacy and confidentiality for patients and their families wherever it was needed. Double bedrooms were provided so that both parents could stay near to their baby on the neonatal unit (NNU). Children and young people's views were listened to and acted on wherever possible. This was demonstrated when accommodation was used creatively on Sarum Ward for a family to be near their child who was near to end of life to fulfil the child's wishes. When a child or young person dies caring for the baby, child, young person and their families continued with memory boxes to meet family wishes. Psychological services were available and actively encouraged for patients and families.

### Compassionate care

- We saw compassionate and caring interactions between staff, patients and their parents or carers. We were told by a young person how the nurses explained procedures calmly to reduce the patients' anxiety.
- Privacy and dignity of patients were protected by the use of children specific bays and curtains used to screen children from other patients when needed. As an example, day surgery unit had two bays used for children in an area where adults were also cared for. Curtains were drawn across to protect children from witnessing adult care and to protect the child's privacy.
- We saw neonatal unit (NNU) staff encouraging and supporting a parent to have skin to skin contact with their child in a kindly way and protected their privacy with screens.
- Thank you letters we saw from patients and their parents/carers included comments about the kindness of staff, their "unconditional support and care", "cheerful, even at the end of a long shift" and "patience and honesty".
- Friends and family test feedback stated the team were very caring and showed no negative comments. A process of real time feedback was also used to gain views from the child's perspective. Hospital governors and volunteers engaged with patients and their families. Results between April and August 2015 showed positive comments.
- One parent we spoke with felt lucky that her local hospital had been full and they had been directed to Salisbury for the care of their child.
- The CQC children and young people's survey results from 2014 showed that staff at Salisbury hospital were better than other hospitals in England in staff being friendly, looking after the child well and were available when parent or child needed attention.
- Between 1 April and 30 June 2015 there were 103 compliments received by the directorate which was split into 14 areas. 50 Of these were from patients or their families from Sarum Ward.

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

- Parents told us they felt involved and informed about the care and options for treatment of their child. Parents were offered the opportunity to be with the child whenever it was appropriate and possible.
- We saw all grades of staff talking to parents of very young children in a way the parents could understand.



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Parents were given time to ask questions which were answered by staff in a relaxed manner. We saw how parents on day surgery unit were gently encouraged to interact with their child who was recovering from a surgical procedure.

- Children and young people were spoken to with respect but in a way they could understand. Staff were aware of the facility for using interpreters if there were language difficulties. A parent of a child with learning difficulties described how a doctor had communicated with the child in short, clear sentences to help understanding.
- Staff in NNU explained procedures to parents and directed them to recognised charitable organisations that would support them further with any ongoing needs.
- The CQC children and young people's survey results from 2014 showed that staff at Salisbury hospital were better than other hospitals in England in keeping parents informed, encouraging parents to ask questions and giving advice to parents on how to care for their child when they went home.

## Emotional support

- Parents told us they felt able to leave the ward or area in which their child was being cared for and their child would be safe.
- Clinical nurse specialists supported children who were living with long term conditions offering outpatient appointments and activities outside of the hospital that would support management of their condition.
- Sarum Ward had a recent occasion when ward facilities were used to accommodate parents and siblings of a child, who lived a considerable distance from the hospital. This was to support the wishes of a child and their end of life care.
- Psychological services actively supported children and their parents. Psychologists attended meetings of the sexual health department, were developing an assessment tool for new fathers with children in NNU and were part of the continuing support offered to diabetic patients.
- There was a teenager's area which was separate to the younger children's play area and could be used for older children to see a therapist or professional in private.
- Children attending for day surgery were provided with reward certificates. Anaesthesia was administered in the surgical theatre as there was no anaesthetic room. Screens were provided to shield the child's view of

equipment but we were told these were not always used by theatre staff. If this was noticed by an registered nurse (child branch) they would ensure the screens were put in place.

- There was bereavement suite which provided facilities in the event of a child death at the hospital. Parents were able to stay with their child and were supported to grieve in a way that suited them. The pathology technician supplied a memory box for parents of a deceased child. The technician would include a lock of hair and take casts of foot prints and hand prints and include anything else the family chose if it was possible. The multi faith chaplaincy supported families in a way suitable for the faith of the family and to meet their wishes.

## Are services for children and young people responsive?

Good



We rated services for children and young people to be good for being responsive. Children and young people and their families' views were sought, listened to and acted upon. Staff worked creatively to provide care and fulfil the wishes of their patients.

Communications between hospital and community services promoted continuous care for the patient. We saw how staff were working with other areas of the hospital to provide support and advice in developing an improved experience for a child or young person who might be visiting an adult area.

Individual needs were taken into account in all areas we visited. Children were prioritised above adults on surgical lists, areas were dedicated to children where possible and actions were taken to improve the environment for children.

All staff we spoke with in every area of the hospital told us they were either working with the children's department to improve services they provided for children and young people or they would seek advice from them if there were any concerns.

Staff worked creatively to capture views of children young people and their families in a way that would be suitable for all ages and abilities including collecting drawings of

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younger children. These feedback methods were shared in all areas of the hospital where children and young people visited. Comments from patients and their families were analysed and acted upon to improve services. A snooker table for teenagers had been provided based on feedback.

Children who needed respiratory assistance could be nursed on Sarum Ward as an alternative to being cared of in an intensive care unit. This was due to advancements in respiratory equipment available. However, the patients would need higher dependency nursing care which had not been commissioned. There were not always enough nursing staff to care for these high dependency patients as well as other patients on the ward.

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

- The children's ward and outpatients department had been redesigned and was completed in 2010. The trust had involved children, young people and their families in the design of the building and its facilities. An example of this was colour changing lights in the bathrooms which were controlled by the child.
- Feedback was actively sought from all ages of children who visited the hospital. Age appropriate methods of gathering views from children and young people were used. As an example, boards designed to look like monkeys asked children to say what they would like to see in the hospital for children. We saw comments where children and young people had added what they thought. Day surgery unit had started using the same method for gathering patient views.
- Sarum Ward was able to care for children with high dependency nursing (HDU) needs if they had the staff. They could accommodate 16 patients on the ward and could increase capacity to 18 if needed. Between May and August 2015, there were three occasions when more than 16 patients were being cared for on Sarum Ward. The HDU care and extra two patients were not funded by commissioners. We saw how a decision was made to care for a baby who needed more specialist care but no bed was available within the local areas meaning a long journey of over 100 miles to the nearest suitable care. A neonatal nurse cared for the baby at the trust overnight and transfer had been arranged to specialist unit closer to Salisbury. This meant the baby and family could receive appropriate care closer to home.
- Sarum Ward, outpatients and day assessment unit had play areas for young children equipped with appropriate toys and activities. There were separate areas for older children and teenagers equipped with activities suitable for their age group. Day surgery unit had a play room for children equipped with a DVD player and suitable viewing material for all ages. Some children were seen in areas used for adults. As an example, the general outpatient department saw children and young people. Within the adult waiting area was a small play area for children to wait for their appointment. Staff could request support from the children's department staff including the play specialist if they needed it. We were told of plans the general outpatients department had for developing a room into a child friendly space by working with nurses from Sarum Ward.
- Sarum Ward had 16 drop down beds positioned next to where children would be nursed. If there were 18 patients on the ward two reclining seats were available. There were private facilities for parents, carers and siblings of patients on both Sarum and NNU. If parents of children on NNU needed to build their confidence before taking their baby home, there were private rooms available for them to use. Sarum Ward had a separate space which they used flexibly just before children went home, if families had travelled a long way or on other occasions to meet the needs of the child or young person. Both areas had kitchens and sitting areas for parents and families away from the ward and facilities to express breast milk and store it for future use.
- There were links with community services such as public health nurses, social services, GPs and community adolescent mental health services (CAMHS). Staff from CAMHS called Sarum Ward seven days a week to assess if they needed to visit. The specialist nurses for children and young people with long term conditions provided links between community care and hospital care for the patients and their families. We spoke to staff from burns unit and Sarum Ward who were working with practice nurses in the hospital to improve care for children in all areas of the hospital. We saw the document for adult nurses to gain competencies with nursing children and young people. This was in development at the time of our visit but was supported by practice educators working with a local university for nurse education to ensure it was valid.

## Access and flow

# Services for children and young people

- Children and young people were supported to access care and treatment across the range of services provided at the hospital this included those at transition between child and adult services.
- Children and young people under the age of 16 years were cared for on Sarum Ward. The policy for admission of 16 and 17 year olds gave guidance and choice to young people regarding whether they would prefer to be nursed on an adult ward. Issues such as clinical need, learning difficulties and safeguarding issues were taken into account. Young people with learning difficulties who were already under the care of a paediatrician would be cared for on the paediatric ward until they were 19 years old.
- Admission to Sarum Ward could be from the emergency department, as planned admission procedures, and from the assessment unit. The paediatric assessment unit took referrals from GP services when advice was needed but there was no need to attend the emergency department. We saw a child admitted from the day assessment unit who required further observation. During the time the patient was waiting for a decision on the need for admission they were able to remain in an area that kept them occupied and was suitable for their age. Patients would be offered an appointment at the day assessment unit at a time suitable for the patient. One parent told us they had their called the unit and had their appointment brought forward as she was concerned about her child's condition worsening.
- Sexual health department operated clinics within the hospital and in ten other locations across Wiltshire. These could be accessed on a self-referral basis for people of 13 years and over.
- Babies in NNU were cared for depending upon their clinical need. There were separate areas for babies who needed close observation and those who could receive more contact with their mothers. There were two intensive care cots and two high dependency cots. For the period between April 2014 and March 2015 these cots were used to 19.7% and 55.9% of their availability respectively. For the same period of time the 10 special care level cots were used to 47% of their availability. Babies who needed longer term ventilation were transferred to a more specialist unit.
- Children and young people on the day surgery unit were able to have both of their parents with them before and after their surgical procedure. There was no anaesthetic room which meant the child was taken straight into the operating theatre before having their anaesthetic. As soon as the child was recovered enough they would be taken to their parent or carer with further nurse observation on the ward area. We saw how nurses encouraged parents to be involved in the care of their child when they were on the ward.
- All surgical lists were arranged with children undergoing their surgery early in the day and before adults where it was possible.
- The outpatients department was used by therapists, specialist nurses and consultants. Therapists used a set of criteria to prioritise their patients. This ranged from two weeks for urgent referrals to 11 weeks for routine referrals.
- The paediatric transfer policy was followed by staff when children needed to be transferred to another area of the hospital or to another hospital. This could be due to the deteriorating condition of a patient or when there was a greater demand for paediatric beds. At the time of our visit we saw how a patient was collected by another specialist unit and how staff communicated with each other to ensure the needs of the child were met.

## Meeting people's individual needs

- Children and young people would be cared for by specialist surgeons regarding their condition for example and orthopaedic surgeon. In addition a paediatrician would offer advice if it were needed. Processes were in place to provide continuity of care and meet the needs of individual children and young people. Older children with learning difficulties up to the age of 19 who were already under the care of a paediatrician would be cared for on Sarum Ward. Young people who may pose a risk to children on Sarum Ward due to extreme emotional state would be cared for on an adult ward. CAMHS services were delivered by an alternative provider who liaised with the ward daily.
- Children we saw before their planned surgery had attended a clinic prior to this and had the surgery explained and the consent discussed. We were told by staff from theatres, day surgery unit and ward staff about a DVD that was being developed to inform children of what to expect when attending for surgery. This was designed to reduce anxieties in children and young people. The play specialist used toys to explain procedures to children and reduce their anxieties. Day surgery unit encouraged children to have a favourite toy available for when they recovered.

# Services for children and young people

- Specialist nurses liaised with the ward staff to provide care for children and young people living with long term conditions or needing end of life care. They also linked with non-NHS organisations to provide information, practical skills and social events to help patients in coping with their long term condition. An example was cooking lessons being held at a local supermarket.
- Staff communicated with social care when there was a concern or a need for further social support. On one occasion social care were informed of a patient's discharge and arrangements were made for support at the time of discharge.
- Physiotherapists used technology and equipment to motivate children and young people in completing exercises or movement. This was so that therapists could assess progress and advise further treatment appropriately. An example of this was using interactive projected images of bubbles encouraging the child or young person to move around and 'burst' them.
- The radiology department had facilities to distract children while they underwent planned procedures. One room had a DVD player with viewing material the child could choose. There were mobiles hanging from ceilings and stickers on walls that children could see.
- The ward area also had rooms used for distraction, play, dining, school work and facilities for parents and families to sleep wash and prepare food. A sensory room on Sarum Ward provided a great environment for children and received positive feedback from patients and their carers. It was equipped with a variety of lights, sounds and cushions and available for use by patients. Nursing staff told us it was useful to help children and young people with learning difficulties, challenging behaviours to reduce anxieties and stay calm.
- Sarum Ward, day assessment unit and the children's outpatient department had appropriate waiting areas, equipment and toys for children of all ages. There was access to secure outside space with age appropriate facilities.
- Written information was provided for children in a format that made it interesting to children and used simple language. Day surgery unit had leaflets telling children what they could expect from their procedure. The burns unit had information for parents so they could support their child.
- The day surgery unit had a recovery area used for adults and children. Each trolley area was separated by a curtain. At the time of our visit we saw a child being

nursed on a trolley next to an adult with no curtain having been drawn between them. The child would be at risk of being upset by witnessing adult behaviours as the adult recovered from their anaesthetic. Recovery area in the main theatre suite had no separate area for children. They used spaces at the end of a room and curtains to obscure the child's view of adults. Wall stickers were used in these areas as a distraction for children.

## Learning from complaints and concerns

- Information was displayed and leaflets were available for patients and their families to feed back their comments to the trust. The friends and family test had been designed for children and young people to contribute their own comments with a child friendly design of an owl and simple language.
- Staff we spoke with were aware of the complaints process and told us they would try to resolve any issues immediately. If this was not possible they would direct the family to the complaints process.
- There was a system of gathering views from patients and their parents on a monthly basis with volunteer staff undertaking a survey. These results were analysed and changes made to improve the experience of the children and parents. Some of the changes in response to this feedback were the purchase of a snooker table for the adolescent room, name boards were introduced as some parents/children could not remember the name of who they were being cared for and ward clerks started working 8am until 6.30pm during the week, to welcome people to the ward and to assist with security.

## Are services for children and young people well-led?

Requires improvement



We rated services for children and young people as requiring improvement for being well led.

Senior staff we spoke with had no clear vision for the future of children and young people's services.

Risks were identified at ward level and fed up to directorate managers but sustainable action was not taken to mitigate the risks. This left some staff feeling unsupported in their specialty.

# Services for children and young people

All the areas we visited told us they were well supported by their managers at ward level. All staff in the areas worked together and supported one another displaying caring attitudes to their colleagues.

Staff demonstrated a patient-centred approach to their work by raising concerns when they thought things could be improved or when there was a perceived risk. Improvement initiatives for children and young people's care were in progress in many areas of the hospital. Theatre staff were developing information for children attending for surgery and burns unit were developing plans for improving care of children on their unit. These were both with the input of the Sarum Ward manager and staff.

The neonatal unit (NNU) had released an APP for mobile phones. This was in conjunction with the area neonatal network with which they worked.

## Vision and strategy for this service

- The trust values of 'being patient centred and safe, professional responsive and friendly' were displayed around the hospital areas we visited. All staff we spoke with knew about the values and demonstrated them in their actions and approach to their work.
- Senior staff did not appear to have a clinical service strategy or clear vision for the future of the service for children and young people. Some senior staff stated they felt there were too many uncertainties in the service to plan effectively for the future. The recent successful tender for children and young people's community services by another provider was having an effect on forward planning in the acute service.
- Staff we spoke with were clear that they wanted to provide the best possible service they could for their patients.

## Governance, risk management and quality measurement

- The directorate clinical governance structure supported the children and young people's services to monitor and report a range of information through the trust governance system.
- Staff we spoke with escalated risks they had identified to their managers and we saw these recorded on the risk register. Actions were not always taken to mitigate risk to patient safety. As an example, the risk register showed that patient safety based on staff ratios had been entered by Sarum Ward manager in December

2014. An action plan was produced which relied on the ward manager researching and using an acuity tool and providing a workforce review for the executive team. The interim plan was to use nursing staff from other areas in the hospital or from the nursing bank. The workforce review had been presented to the trust board in August 2015. The acuity tool for staffing levels based on patient need was being trialled by the ward and reported to managers but was not embedded as a tool to identify levels of nursing staff needed. No action had been taken following the workforce review.

- Children's services were part of the clinical support and family services directorate. There was representation when required at trust board from the directorate's senior nurse and a clinical director. The senior nurse would raise issues on behalf of the ward managers for neonatal unit (NNU) or Sarum Ward. The clinical director would raise issues on behalf of the clinical medical leads. The trust chairman acted as the non-executive director as a champion for children and young people's services on the trust board.
- The trust board discussed a six monthly skill mix review for all services which included shortfalls in nursing hours of children and young people's services and ward closures. The August 2015 board meeting noted concerns raised by the paediatric matron regarding the children's unit not meeting the 2013 RCN guidelines for safer staffing. No action plan for addressing the concerns raised was noted at this time.
- We saw minutes of monthly team meetings held in sexual health, NNU and Sarum Ward where discussions included clinical updates, updates on risk, complaints and shared learning.
- Staff in all areas we visited were clear about their roles and understood what they were accountable for. Safeguarding overview was reported to the trust board on a quarterly basis with the most recent report having been written for the period July to September 2015. This included progress of the identified actions for safeguarding concerns incorporating staff compliance with training and any reported child protection issues. A training needs analysis had been produced by the named nurse for children's safeguarding and a strategy identified to meet the guidelines for staff working with children. This had been agreed with the trust board.



# Services for children and young people

- Results from national and internal audits were discussed at team meetings and reported to the trust board with action plans identifying how improvement could be made.

## Leadership of service

- Managers of Sarum Ward and NNU were confident in their skills with children and young people they cared for as well as providing expert advice to other staff. All the staff we spoke with who cared for children in other areas of the hospital told us they received support and advice from the Sarum Ward manager. The staff we spoke with were aware of who their immediate managers were and described the managers of both Sarum Ward and NNU as being supportive and approachable.
- The demands of clinical work often prevented the ward manager fulfilling their supervisory and management role.
- Senior management were not familiar with the acuity tool being trialled by Sarum Ward and did not show an insight to the specific challenges of caring for children in the clinical environment.
- All consultants had job plans which were appropriate for their specialty. These were linked to the appraisal process.

## Culture within the service

- Throughout the areas we visited there was an atmosphere of caring and supportive interactions between all grades of staff. Sarum Ward staff were also involved in improvements for children and young people in other areas of the hospital working in a collaborative way to ensure children were placed at the heart of all those areas in the hospital which provided care and treatment for them.
- We saw supportive, friendly and appropriate communications between staff and patients. Parents were given time to ask questions even when the staff were visibly busy and told us they felt fully informed about their child's care.
- Staff worked together flexibly to cover the changing needs of the children often working extra shifts when bank nurses were unavailable. NNU, burns unit, Sarum Ward and day assessment unit would move staff between them when they were able, in order to support the areas that were busy.

- Staff felt cared for by their colleagues and we saw nursing staff encouraged to leave the ward at the end of their shift. However, the extra shifts being worked by nursing staff was making them feel some level of exhaustion.
- We saw how staff were working with different areas of the hospital to provide safe and appropriate care for children and young people such as when there were children on the burns unit and no registered children's nurse available. Different options were being explored by the burns unit and the children's ward managers. The play specialist and oncology nursing staff worked together to provide sterilised toys for oncology patients.

## Public engagement

- In each area of the children's unit we saw opportunities for children, young people and their families to feedback their thoughts on the service they received. The methods used were designed to enable children of all ages to feedback often with a picture of what they would like to see. It included the friends and family test which gave much positive feedback.
- The specialist diabetic nurse linked with private organisations to provide support for families of diabetic children. These have taken the form of 'fun days' and cooking sessions outside of the hospital premises and used as an opportunity to encourage feedback from patients about the diabetic service. The oncology service responded to results of an annual questionnaire for children and young people by arranging a greater variety of foods to be made available while children were in hospital.
- The children's unit had engaged with charities to provide improvements for the children and young people. Funds raised by the hospital's charity had been used to finance much of the purpose built children's unit and children and young people had been consulted in the design of the new build.
- Child friendly surveys developed and used by children's unit staff were also used in other areas of the hospital where children were nursed.

## Staff engagement

- Most staff we spoke with would escalate a concern through their line manager.
- We were told by Sarum Ward staff that if they felt an improvement was needed or there was a need for more

# Services for children and young people







equipment they could approach the ward manager who would usually manage to provide from the ward budget. One instance is when replacement soft spoons are needed for children who have had cleft palate surgery.

- Team meeting minutes from all areas recorded the views of the staff with actions allocated to staff members and updates on previous actions.

## **Innovation, improvement and sustainability**

- We saw areas of practice that were being reviewed and changed in order to improve the services. Sarum Ward staff worked with other areas of the hospital to improve the care of children and young people. A group of professionals including anaesthetists and nursing staff from day surgery unit, main theatres and Sarum Ward were developing a DVD for children and young people to view before their surgery, informing them of what to expect.
- The NNU had very recently released an App for mobile phones. This was for parents to access for support and advice and was developed in conjunction with the Thames Valley and Wessex Neonatal Network. It was too early for any feedback to have been received.
- Sarum and burns unit were investigating how they could provide safe care with appropriately qualified nurses in a cost effective way. They were in discussion with the directorate manager and using expertise from the regional burns network. This had prompted the development of competencies in nursing children and young people that adult nurses could complete. Practice educators were supporting the initiative.
- Sexual health department had been commissioned in 2015 to extend their service to a larger area of the county.
- The trust had a process where staff could be recognised for work and achievements. Sarum Ward had been awarded a Pride in Practice Award in March 2015 for working flexibly to fulfil the wishes of a palliative patient and their family.
- Partnership working was encouraged throughout the children's and young people's services. NNU were part of the Thames Valley, Oxford and Wessex Neonatal Network which supported staff to provide high quality care in their specialty.

# End of life care

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

## Information about the service

Palliative and end of life care encompassed all care given to patients who were approaching the end of their life and following death. Care of the end of life patient could be delivered on any ward or within any service of the trust and included aspects of basic nursing care, specialist palliative care, bereavement support and mortuary services. The definition of end of life includes patients who are approaching the end of life when they are likely to die within the next twelve months, as well as patients whose death is imminent.

During the year 2014 the trust reported there had been 762 deaths in the hospital. Between April 2014 and March 2015 there were a total of 454 referrals made to the specialist palliative care team. Over the past five years that had been an increase in referrals to the team of 45%. The team had responded to 80% of referrals within 24 hours.

The trust has its own ten bedded hospice located on the site that is physically connected to the hospital. Based in this building is the Salisbury Specialist Palliative Care service. This is an integrated service that provides an inpatient service to the hospice, a community service, a day care service, a bereavement service and a palliative care hospital team. The hospice, which has its own nursing staff team, falls within the governance of the trust. Located within the Hospice is a family support team made up of social workers. All hospice staff were employed by the trust.

Patients can be admitted to the hospice from the community and from the hospital. Reasons for admission were complex symptom control, rehabilitation,

multi-disciplinary assessment, respite and terminal care. Members of the team provided a service to the acute trust for patients who had an advanced and progressive palliative illness and were usually within the last six to twelve months of their life. The care of a patient within the hospital remained under the core clinical team with the palliative care team offering specialist advice.

The HPCT comprised a team of three band 6 (1.9 wte) and one part-time band 7 team leader who supports the community and hospital clinical nurse specialists and a team of three consultants, 2.2 whole time equivalents, who divided their time between the hospital, the hospice and the community team that worked out of the hospice. The trust had employed two nurse end of life care facilitators, 1.3 whole time equivalents, who were working on the wards providing training to staff around the introduction of new documentation and process for end of life care.

During the inspection we visited eight wards and the emergency department. We spoke with five patients and ten relatives. We talked to five consultants, eight nurses, four health care assistants and two ward receptionist/administrators. We visited the bereavement suite, which incorporated the mortuary, and also the chaplaincy service. We spoke with staff working in these areas and also portering staff. We also met with the medical director who is the board lead for end of life care in the trust.

# End of life care

## Summary of findings

We have judged the overall end of life service as good. The Trust had taken part in the National Care of the Dying Audit 2014 and had poor results and put in place an action plan which was being reviewed every 6 months. In the most recent review in September 2015 we saw there had been improvements made both in the organisational and clinical key performance indicators, with many of the red and amber ratings having improved and changed to a green rating. The leadership needed to develop a trust wide policy for end of life care.

The Trust could organise rapid discharges effectively but there were delays usually due to the lack of carer/care package availability in the community. The trust had completed local annual end of life care audits which included data on patients' preferred place of death in 2012, 2013 and 2014. The 2015 audit was delayed until March 2016 whilst the Personalised Care Framework was rolled out across the Trust.

There was an improvement plan in place for end of life care that was being overseen by a strategy steering group. There had been a number of changes put into place in the previous twelve months. These were initiated following the results of the National Care of the Dying Audit that was completed in 2014 and also to respond and implement national directives such as the NICE Quality Standard on End of Life Care. These included a new personalised care framework, to replace the discontinued Liverpool Care Pathway, improved rapid discharge processes and the appointment of two end of life care facilitators to roll out the new documentation and provide training. Whilst some of the changes were not fully imbedded the staff were committed and motivated to provide an improving service and embraced the initiatives that were being developed by the end of life steering group.

There was evidence of leadership in both the palliative care team and at board level however despite the work undertaken to deliver the improvement plan there was no trust wide policy on end of life care. This was combined with limited representation at the strategy steering group from board members.

Staff understood their responsibilities to raise and report concerns, incidents and near misses. They were clear about how to report incidents and we saw evidence that learning was shared across the teams.

Equipment was readily available and properly maintained for the use of patients. Anticipatory medicines were always available and patients being discharged home had their medicines provided promptly.

There were processes in place to assess and respond to patient risk. Staff were able to contact members of the palliative care team for advice about deteriorating patients and this team was responsive and supportive to urgent requests for input. The palliative care team were staffed sufficiently to provide the advice and support that was requested.

The Trust was providing a seven day service from members of the palliative care team but this was only currently being funded until end of March 2016. The team told us that funding of this service was subject to on-going review and has been funded for a further 12 month period to March 2017.

There was a range of training that was provided for members of the palliative care team and also training that was available to other staff if they could be released from their duties but there was currently no mandatory end of life training for staff trust wide.

Patients received compassionate care and were treated with respect and dignity by staff. Patients were communicated with sensitively and kept informed about their diagnosis and prognosis.

Staff worked in a positive and open culture and felt supported by their colleagues and line managers. Staff felt valued by the trust and were engaged with the trust objectives.

# End of life care

## Are end of life care services safe?

Good



We judged the safety of end of life care as good.

Staff understood their responsibilities to raise and report concerns, incidents and near misses. They were clear about how to report incidents and we saw evidence that learning was shared across the teams.

Equipment was readily available and properly maintained for the use of patients.

Records were completed and stored appropriately to protect patient confidentiality.

Anticipatory medicines were always available and patients being discharged home had their medicines provided promptly.

Staff working in the hospital palliative care team were up to date with their mandatory training.

There were processes in place to assess and respond to patient risk. Staff were able to contact members of the palliative care team for advice about deteriorating patients. Nursing and medical staff said the team were very responsive and supportive to urgent requests for input. The palliative care team were staffed sufficiently to provide the advice and support that was requested.

### Incidents

- Staff understood their responsibilities to raise concerns, to record safety incidents and near misses reported them appropriately. Feedback was provided to staff and learning disseminated. On one ward staff told us they received feedback from incident reports at ward meetings. After the morning handover meeting the trained staff shared any issues pertinent to their patients and any incidents that needed reported were discussed. We saw minutes from one ward team meeting which included the details of the incidents that had been reported.
- There had been fourteen incidents reported in respect of end of life care and the mortuary services during the fourteen month period between September 2014 and October 2015. Three of these were recorded as minor incidents and the others as no harm. We saw that the

action or investigation was recorded. This included arranging meetings to discuss concerns, making safeguarding referrals, taking action to increase the mortuary capacity and escalating issues to other departments. One example was the mortuary receiving items unlabelled and not in the correct property bags. The bereavement team arranged for the wards to receive an updated copy of their policy for ward staff to read and sign to say they were aware of the guidance.

- Lessons were learnt and action taken as a result of investigations. On one ward we saw feedback from recorded incidents displayed on the staff notice board. We saw notes that showed discussions around incidents were also held at the quarterly ward meetings. All staff we spoke with were aware of how to report incidents and the process to be followed. On another ward following a number of incidents around falls the ward manager attended the hospital falls forum meeting. The assessment tool was subsequently updated and intentional rounding, (checking patients every hour) was started. From there it had been recorded that the falls rate for the ward had decreased.
- New fundamental standards and regulations for the provider came into force in November 2014 regarding Duty of Candour. Nursing staff we spoke with were aware of the duty to be open and honest with patients and relatives about any care or treatment that may have gone wrong. On one ward we were given an example of how a patient had required restraining and how this had subsequently been investigated and the information given to the family. We were told of another example where after a patient had fallen and broken their hip the family were called with regular updates. When the risk analysis was completed a copy of the report was sent to the family. Staff we spoke with said they believed they worked in an open culture and would be confident about reporting concerns or possible mistakes that had been made.

### Cleanliness, infection control and hygiene

- The hospice building appeared clean and hygienic. The cleaning staff had a cleaning schedule to follow and the building was regularly checked by the manager. We were told the cleaning team responded quickly to requests for rooms to be deep cleaned. Relatives we spoke with said the rooms were well maintained and they had no concerns over cleanliness.



# End of life care

- There were hand hygiene dispensers in place and written reminders for visitors to clean their hands. We observed staff and visitors following the correct procedures and wearing the appropriate protective clothing.

## Environment and equipment

- The National Patient Safety Agency recommended in 2011 that all Graseby syringe drivers (a device for delivering medicines continuously under the skin) should be withdrawn by the end of 2015. An alternative had been provided across the trust and guidance about the use of the new equipment was provided on every ward.
- Staff told us there was a sufficient supply of syringe drivers and pressure relieving equipment and this equipment was provided promptly when requested. There was a central store of syringe drivers which were maintained by the clinical engineering department. Checklists were in place on the wards to remind staff of the correct procedures to use.
- The mortuary was well organised and appeared clean and well maintained. Equipment servicing was up to date and recorded.

## Medicines

- Patients receiving end of life care were prescribed anticipatory medicines, these were prescribed in advance to promptly manage any change in the patient's pain or symptoms. If however, further advice was required this could be sought from the end of life care team or the Hospital Palliative Care Team (Clinical Nurse Specialist or Consultant) Monday to Friday 9-5, or the 7 day working Clinical Nurse Specialist at weekends, or out of hours advice from the Hospice staff nurses or on call doctor available 24 hours a day, 7 days a week.
- Patients being discharged home could have their medicines ready within one hour. The discharge team said the preparation of medicines for rapid discharge patients was done effectively and did not cause delays.
- In the new information pack on end of life care, which was available on every ward, there was advice and guidance for staff in relation to medicines. We spoke with three end of life link nurses, all were well informed about end of life medicines and knew where to access further information. On two wards we checked the storage of medicines and saw that all the normal end of

life medicines were there. We saw that the controlled drug book was located and completed correctly. In the patient's records we looked at medicines correctly and clearly recorded.

- We observed one of the end of life care facilitators initiate a medicine review by directing ward staff to contact the clinical nurse specialist for Parkinson's disease. This followed questions raised by the ward staff in discussion with the end of life care facilitator about a patient.
- The clinical protocols for the prescription for medicines for the five keys symptoms at the end of life had been reviewed in September 2014. A recommendation that the review should include a prescription for dyspnoea had been completed and recorded.

## Records

- We looked at a sample of 12 patient records and saw that the Do Not Attempt Cardio Pulmonary Resuscitation (DNA CPR) forms were in place and completed in most cases. The forms that were not completed fully had been completed whilst the patients had been in the community and had not been completed by trust staff. We saw an example where the ward staff had completed a further DNA CPR form as the community form did not contain sufficient detail about the involvement of the family in the decision making.
- A new personalised care planning format had been introduced and was being rolled out across the trust by the recently appointed end of life care facilitators. This document was in two parts, one was a personalised nursing care plan and the second part was a personalised medical and nursing care plan for the last few days of life. The details and information on the forms complied with the recommendations of the latest guidance. We saw a sample of these forms that had been completed. They recorded what discussions had taken place with the patient and relatives, including recognition that the person was dying and also with regards to spiritual or cultural needs. Nursing and medical information about symptom management and fluid and food intake was also clearly recorded. The forms provided guidance for staff, including information about anticipatory prescribing.
- Records were stored securely and patient's confidentiality was protected.
- We were shown the recording system for the movement of the deceased through the mortuary. There was a

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clear recording process in place from the point of arrival until the deceased was collected by a funeral service. We looked at a sample of the recording and saw that it was completed in detail with appropriate signatures and dates in place.

- The bereavement team had a checklist they completed for every patient they received into the mortuary. The sections included all the personal information about the deceased as well as the next of kin, potential tissue donation guidance and also a checklist of Standard Afterlife Guidelines for the mortuary technicians.

## Safeguarding

- Systems, processes and practices were in place to keep people safe identified, through policies, procedures and training for staff. All of the palliative care team and end of life facilitators had undertaken the trust's mandatory safeguarding training. Safeguarding information was available on all the wards we visited and staff had completed the mandatory safeguarding training. Staff were aware of how to report concerns and the process to follow

## Mandatory training

- Staff working in the hospital palliative care team were up to date with their mandatory training. Staff explained how they received reminders via email and from their managers when updates were due and had to be booked. The staff team working in the hospice were 91% compliant with mandatory training.

## Assessing and responding to patient risk

- On every ward there was a daily ward meeting where concerns about patients were discussed. Nursing staff said they had a good rapport with the medical staff and that they listened to any issues that arose. Patients who were receiving end of life care and whose treatment was documented on the new personalised care framework had their regular observations recorded and a three times daily review of their nursing goals undertaken and documented in their records.. Staff explained how everyone was listened to at the morning meetings and that discussions about identifying a dying patient could happen there. The discharge team also attended these meetings. If required they could then start a rapid discharge process.
- Staff were able to contact members of the palliative care team for advice about deteriorating patients. Nursing

and medical staff said the team were very responsive and supportive to urgent request for input. The recording in the personalised care framework provided guidance for staff around nutrition and hydration for the individual patient. Staff explained how it was important to maintain mouth care for patients after they had stopped receiving fluids orally.

## Nursing staffing

- The hospice was staffed by its own team of nursing and care assistants, who only worked in this location. The hospice also accommodated family support services, who also worked with the community service.
- The trust employed three clinical nurse specialists to provide palliative care advice and support to staff across the hospital. Staffing of this team constituted three band 6 nurses (1.9 wte) and one band 7 (0.8 wte) team leader. These nursing specialists advised on symptom control and complex discharge planning. They also had a role in providing support and education to staff and helping with transfers to the hospice inpatient unit. Together with the medical staff they provided an out of hours on-call advice service for staff.
- Since May 2015, the trust had also employed two nurses, at an equivalent of 47 hours per week, as end of life care facilitators. These staff, a band 7 and a band 6 nurse, were providing support, advice and training across the hospital wards to staff. They were delivering training across all the wards on the new documentation, the personalised care framework and the accompanying guidance. They were covering two wards at a time for two weeks and planning that all wards would be completed by the end of January 2016. The process ensured that every staff member on the ward engaged with the nurse specialists at some point over the two weeks.
- Each ward had a named link nurse for end of life care. These staff have completed a two day palliative care training programme run by the palliative care team. They were also required to have spent time shadowing the palliative care team.

## Medical staffing

- Medical support for palliative care was provided by a team of three consultants, who worked across all wards, the hospice and also undertook work in the community. The consultants provided advice and support to the clinical nurse specialists and to hospital medical staff.

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They also provided education sessions on palliative care for the junior doctors. The consultants told us the current cover arrangements were adequate but considered that the nursing cover was stretched at times.

- We spoke with two consultants (not palliative care) working on two separate wards. They told us the palliative care consultants were very responsive to requests for input and felt there was positive communication and sharing of knowledge.

## Major incident awareness and training

- The trust had a major incident policy in place that staff we spoke with were aware of how to access.
- There was an escalation plan in place for the mortuary. Following an identified risk with the storage capacity, temporary storage equipment had been provided and was available if required.

## Are end of life care services effective?

Good



We judged the effectiveness of end of life care as good.

The Trust had taken part in the National Care of the Dying Audit 2014 and had poor results. The Trust had an action plan in place and reviewed progress against this. New documentation to support the end of life care pathway, called the Personalised Care Framework (PCF) had been introduced. The end of life care facilitators who were undertaking this work were motivating their colleagues with their enthusiasm for the new initiatives with support from the palliative care team and overseen by the End of Life Care Steering Group. We heard from staff that the new Personalised Care Framework and education programme had been positively accepted by clinical staff on the wards.

The trust had systems to ensure there was an appropriate identification of people requiring end of life care, either on admission or whilst deteriorating as an inpatient. The palliative care team responded to 80% of referrals within 24 hours.

End of life care training was not mandatory for all staff but various training was available if staff were able to be released.

There was evidence of excellent multi-disciplinary working across hospital teams and with the staff in the hospice. Staff communicated effectively and information was shared. The palliative care team responded quickly to requests for advice and support.

Pain relief was effectively managed and recorded and anticipatory medicines were appropriately prescribed.

## Evidence-based care and treatment

- The trust had taken part in the National Care of the Dying Audit in 2014 and had not achieved six out of the seven key organisational targets and had scored below the national average for nine of the ten clinical key performance indicators. Action had been taken to improve the performance in all these areas. The trust were in the process of completing the latest National Care of the Dying Audit at the time of the inspection.
- Following the withdrawal of the Liverpool Care Pathway the trust had implemented a number of improvements plans to replace this methodology. Action was also being taken to address the five core recommendations for care of patients in the last few days of life in the Department of Health End of Life Care Strategy 2008. The recommendations from “One chance to get it right” published by the Leadership Alliance for the Care of the Dying were also being worked towards. Care was being delivered in line with National Institute for Health and Care Excellence (NICE) guidance S13.
- Patients had their needs assessed and their care planned and delivered in line with evidence-based, guidance, standards and best practice. The new personalised care planning document was in two parts, one was a personalised nursing care plan and the second part was a personalised medical and nursing care plan for the last few days of life. The details and information on the forms complied with the recommendations of the latest guidance.
- Nursing staff we spoke with were positive about the new personalised care framework documents and were aware of the new end of life care pathway. They thought it was easy to follow and the training had helped ensure the forms were completed consistently. Several staff commented positively on the rate of change over the previous six months and the increased awareness of all clinical staff around the changes being implemented in the end of life care pathway in the hospital. Staff were very positive about the work being done by the end of

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life care facilitators, both in terms of the training and the on-going support they were providing to staff. One senior ward nurse said their knowledge and enthusiasm was really motivating to all the team on the ward. A consultant commented that the new care planning document had improved the confidence of all the staff on the ward around the end of life pathways. The trust has been running an improvement Commissioning for Quality and Innovation (CQUIN) initiative project called the Conversation Project. The CQUIN payment framework enables commissioners to reward excellence by linking a proportion of healthcare funding to the achievement of local quality improvement goals. The project was aimed at helping patients talk about their wishes for end of life care, before a medical crisis occurred. This would help the planning and recording of the care and treatment that was agreed with the patient and their family and help ensure that a ceiling of treatment plan is in place. The standards identified as being improved by this project included the early identification of a patient approaching end of life, recording of conversations with the patient and relatives and ensuring there was good recording of the medical plan that was regularly reviewed. Agreement had been reached to run the CQUIN scheme for a further year to build on the progress that had been made so far.

- The chaplaincy service based its practice on the updated NHS 2015 Chaplaincy guidelines, Promoting Excellence in Pastoral, Spiritual and Religious Care. These had been updated from the original 2003 guidelines. The service had reviewed itself against the new guidelines and updated various leaflets and practice guidance for the staff and volunteers. The team had provided an information sheet for the new end of life personalised care framework and had also provided an information folder to every ward about spiritual care.

## Pain relief

- Patients who were identified as requiring end of life care were prescribed anticipatory medicines. These “when required” medicines were prescribed in advance of need to be available to manage changes in patients pain or symptoms. Information was provided to staff in relation to pain management and for the medicines used for pain relief.

- Pain was monitored using an assessment tool. Pain scoring was completed for patients everytime their observations were recorded. For patients on the end of life care framework this was a minimum of three times a day.
- Staff had quick access to supplies of syringe drivers and the medicines to be used with them when required.

## Nutrition and hydration

- Nutrition and hydration needs were included in patient’s individual care pathways. In patient records we saw that nutritional assessments had been completed and were regularly updated. In the new personalised care framework document guidance was included around feeding and fluids. Staff were required to complete whether artificial hydration and nutrition was appropriate.

## Patient outcomes

- The regular ward meetings and communication between medical staff ensured there was an appropriate identification of people requiring end of life care, either on admission or whilst deteriorating as an inpatient. The palliative care team responded to 80% of referrals within 24 hours. The level of input depended upon the needs of the individual patient. The Trust was planning a further local end of life audit in March 2016 after the complete roll out of the Personalised Care Framework in line with its previous annual local audits undertaken in 2012, 2013 and 2014. The Salisbury Specialist Palliative Care service collected data both nationally for the Minimum Data Set and quarterly statistics for local Clinical Commissioning Groups. These included the numbers of deaths in the hospital known to the Hospital Palliative Care Team.
- The trust had participated in the National Care of the Dying Audit in 2014 and met only two of the 17 organisational and clinical KPIs. An action plan had been developed in 2014 which was overseen by the End of Life Care Steering Group. The action plan had been reviewed on a 6 monthly basis. In the most recent review in September 2015 there had been improvements made both in the organisational and clinical key performance indicators.
- The Trust had undertaken local annual end of life care audits in 2012, 2013 and 2014 which included data on patient’s achieving their preferred place of dying. The 2015 local annual audit was delayed until March 2016

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whilst the Personalised Care Framework was rolled out across the Trust. In the meantime, the end of life care team had kept a real time database which included preferred place of dying and if this was achieved.

- A survey of bereaved relatives had been undertaken in 2014 and had produced mainly positive feedback about their experience and that of their deceased family member. The Trust were also taking part in a VOICES survey which is a survey designed and validated by the University of Southampton to look at the experiences of bereaved relatives about the care of patients who had died both in the Hospice and the acute Trust in the previous 6 to 12 months..
- The hospital was not participating in any national accreditation scheme in relation to end of life care.
- Palliative care was provided to patients with a different life limiting illnesses. Between April 2014 and March 2015, 69% of patients supported by the palliative care team had cancer and 31% had non cancer related conditions

## Competent staff

- The end of life care facilitators were providing training to all ward staff around the new documentation that was being introduced. The training included input on the associated guidance, the completion of the new forms and when these were to be utilised. A programme was in place to have all wards completed by the end of January 2016. On the wards we visited where the training had been delivered we found all staff had completed it. This included reception staff and clinical staff. Staff were aware of the location of the supporting guidance on the ward and the staff to contact if further clarification was required.
- From January 2016 all newly appointed health care support workers will receive two hours of end of life training as part of their trust induction. Also from this date overseas nurses and newly qualified nurses attending preceptorship courses will receive a half day training session on end of life care.
- Each ward had a named link nurse for end of life care. These staff had completed a two day palliative care training programme run by the palliative care team. They were also required to have spent time shadowing the palliative care team. We spoke with three link nurses who described their role and described the priorities of care for the dying patient. They felt empowered to

support and advise staff and said how well supported they were by the palliative care team. Staff on the wards were aware of who their link nurse was and the role they fulfilled.

- There was no mandatory training for end of life care in trust but the hospice ran an education programme. Staff across the trust could apply to undertake courses that were run. The courses included training for qualified nurses, health care assistants and administration staff on areas such as communication and managing difficult situations. The trust annual end of life reports stated there was a need to establish a formal end of life education programme for staff with some mandatory components but this was yet to be put into place. The report stated that the trust needed to ensure that staff were able to be released to attend training, however the palliative care team said this was not always possible. The specialist palliative care service had produced an education strategy document which covered their aims and challenges for the next five years. This had identified four strategic aims. These were working towards having a sustainable education programme, promoting supporting and providing palliative care education to the area they serve, working with other agencies to look at ways of sharing knowledge and resources and to produce an annual action plan and report to review and evaluate education provision.
- The palliative care consultants provided training to the junior doctors with 5 to 6 formal teaching sessions every year.
- Bereavement officers completed in-house training that was provided alongside the trusts mandatory training. We saw records that showed this was being update annually. This training contained competencies around areas such as what issues were reportable to the coroner's office and the process for contacting the out of hour's emergency registrar. Staff said they were well supported by their manager and that advice and guidance was always available when required.
- Palliative care staff said they had an appraisal completed within the previous twelve months. Staff told us they were well supported by managers and that there was a supportive culture on the wards from all the senior staff.
- Within the hospital palliative care team and the hospice team staff were achieving 90% compliance with



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mandatory training. A band seven nurse on one ward explained how they got an email every month with all the staff training that was due to expire. Staff were given time away from the ward to complete their e-learning.

## Multidisciplinary working

- All staff we spoke with were positive about multidisciplinary working. We observed ward meetings between palliative care staff, ward based nurses and medical staff which were professional and effective and ensured high quality care. We spoke with a patient who had been admitted through the emergency department then moved, following an operation, onto the orthopaedic ward and then to the hospice. The consultant surgeon had liaised with the palliative care team and there had also been input and support from the occupational therapy and physiotherapy teams. There had also been communication with the GP in the community. Two consultants we spoke with said the palliative care team were good at networking throughout the hospital and always responded quickly to requests for advice and input about patient care and treatment.
- The end of life care facilitators told us there was good engagement from the medical staff over the new documentation that was being introduced.
- There were multidisciplinary team meetings on every ward at the start of the day. Notes were not kept of these meetings but the ward board was updated and relevant information was entered into a patient's notes. Nursing staff could discuss any concerns around end of life care before the medical staff visited a patient.
- Within the hospice there was good engagement with local GPs. The team were informed electronically about patients admitted from the community who were already known to the specialist palliative care team. The hospice had good links with the rest of the hospital, for example oncology consultants attended a weekly community meeting with other staff in the hospice. A relative of a patient treated by the community team being admitted to the emergency department rang the hospice. The palliative care consultant contacted the emergency department to liaise over treatment.
- The chaplaincy service were represented on the trust end of life strategy group and also attended the hospice multi-disciplinary meeting.

- Staff on the wards felt having the expertise of the hospice staff on site helped with the sharing of good practice.

## Seven-day services

- The palliative care team provided a full service to the hospital Monday to Friday between 09.00 and 17.00. This included advice, support and clinical assessments from nurses and consultants. At the time of the inspection the service was piloting a seven day working of clinical nurse specialists until March 2016. This provided assessments and telephone advice for patients, carers and healthcare professionals at weekends between 09.00 and 17.00. There was also a 24 hour telephone advice line that was manned by the Hospice nurses and supported by the on-call medical team.
- Consultants and nurses were keen for the seven day service to be extended but said they felt this required additional staffing to be run effectively. A business case for this service had been submitted as part of the end of life strategy plan.
- The hospice inpatient service accepted admissions seven days a week.

## Access to information

- Staff had access to the information they required to provide good patient care.
- Every ward had been provided with an information folder about the new end of life care pathway which accompanied the new care plans that were to be completed. Another folder had also been supplied to every ward about patient's spiritual needs. Staff also had access to hospital policies and guidance via the trust intranet.
- There was also a 24 hour telephone advice line that was manned by the Hospice nurses and supported by the on-call medical team that the hospital staff could use when required..

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

- Nurses we spoke with were aware of the Deprivation of Liberty Safeguards and we were shown the process that was followed and the forms that were to be completed.
- Not all nursing staff had done training on the Mental Capacity Act but more senior staff understood the process and procedures to be followed if a patient's ability to provide informed consent was in doubt.

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Medical staff would be involved if a capacity assessment was required. Information about a person's capacity was recorded in the patient notes, and their involvement in the decision making was recorded in most cases. However in three sets of notes we looked at it was recorded that a person lacked capacity but there was not a record of how or why this decision had been made. Three patients told us about their involvement in the decision making around their treatment and medicines. They also described how their families had been involved and informed of all the ongoing decisions and that their consent had been sought.

- Staff told us how best interest meetings were organised and the decisions recorded. We saw the record of one meeting which was recorded in the patients notes.

## Are end of life care services caring?

Good



We judged caring in end of life care to be good

Compassionate care was consistently provided to patients who were treated with respect and dignity by staff.

Communication was sensitive and patients and relatives were kept informed about their diagnosis and prognosis.

Patients and their relatives were involved and informed about their care and any decisions that were required to be made about treatment.

Patients and those close to them received support to cope emotionally. There was a family support team based in the hospice that provided bereavement support and proactively contacted bereaved relatives. The hospital chaplaincy service also provided support to patients, their relatives and staff. Staff also supported each other recognising how different people can react to end of life situations.

### Compassionate care

- Staff provided compassionate care and support to patients and treated patients and relatives with dignity and respect. We spoke with five patients and ten relatives and all said they were well informed about their diagnosis and treatment and were communicated with sensitively by staff.

- We saw a selection of 13 letters that had been sent to the customer care department that praised the end of life care that patients or relatives had received. These mentioned the palliative care team and the ward based staff. On the wards there were also numerous cards from relatives thanking the staff for their care and work.
- Three staff members who had experience of relatives receiving end of life care in the hospital during the previous two years told us the care was excellent and that they could not fault the approach of any of the staff.
- We spoke with a family whose relative had died after being admitted to the emergency department. They explained how the consultant had telephoned two weeks later to ask if there was anything else they needed to know or wished to discuss. The end of life care was described as "exemplary" and the family said they felt well supported by all the staff in the department.
- We observed patient care in the hospice, where six patients were receiving symptom control and four were on end of life care. We saw staff being caring and patient, spending appropriate time with patients. Staff ensured they had the required information about individual patients before talking to them and then providing care in a friendly and supportive manner.
- Patients we spoke with in the hospice described the staff as "brilliant", "excellent" and told us they had no complaints about the care and support from any of the staff.
- We observed a discussion between a patient and a consultant about their treatment and diagnosis. The conversation was realistic and compassionate with clear answers given to the questions asked. They discussed a preferred place to die and the possibility of respite care in the hospice.

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

- The patients and relatives we spoke with said they felt the hospital staff explained any matters to do with their illness or treatment in an informative and understanding manner.
- One set of relatives told us how they had been telephoned several times at home with updates and how they had been involved in the discussion with the

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consultant about their relatives preferred place of dying. They said all the potential issues were explained and also how they would be able to access additional support from the community service.

- Two sets of relatives explained how the chaplaincy service had spent time with them and made sure they were clear about the support they could provide.

## Emotional support

- The emergency department ran a follow up bereavement service for relatives of patients who had died after being admitted through the department.
- The family support team based in the hospice provided a service to any relatives of patients known to any branch of the specialist palliative care service. The service had a team of trained bereavement counsellors who were available to relatives. Staff contacted bereaved relatives immediately following a death and then would follow up this phone call four to six weeks later. Staff followed a policy or bereavement pathway.
- Three times a year the family support team ran a bereavement support group for six weeks. These groups could possibly lead to further social contact for participants and help with avoiding social isolation after a bereavement. The team sent a card to families on the first anniversary of a bereavement.
- The chaplaincy service was available seven days a week and provided a service to patients, their relatives and staff. The service promoted that it provided spiritual, pastoral and religious support. The service could provide memorial services for staff, both religious and non-religious and also ran regular “days of reflection” when anyone, including staff, could visit the chapel area, light candles and listen to prayers or poetry that were recited throughout the day.
- Following a day, recent to the inspection visit, when four patients had died on the same ward in one day the end of life care facilitators had organised a supportive debriefing session for staff. The chaplaincy service also attended this meeting.
- The hospice staff ran a well-being group for all staff who worked there; this was attended by the chaplaincy service.
- Several nursing staff said their teams were good at providing emotional support to patients and relatives. We were told how staff will get involved and try provide support, answer questions and listen to people. Staff explained how they are offered debriefing sessions if

they find something upsetting. One nurse said her colleagues were “excellent at supporting one another and recognised how different people can react to dealing with end of life care”.

## Are end of life care services responsive?

Good



We judged the responsiveness of the service as good.

The Trust could organise rapid discharges effectively but there were delays usually caused by the lack of carer availability in the community.

The trust had completed local annual end of life care audits which included data on patients’ preferred place of death in 2012, 2013 and 2014. The 2015 audit was being delayed until March 2016 whilst the Personalised Care Framework was rolled out across the Trust.

Patients at the end of life could be provided with a side room if one was available but this was not always possible. There was some accommodation available on the hospital site for relatives and there was also some provision for overnight stays on the wards with the use of collapsible beds.

The palliative care team responded well to the needs of patients and also the needs of the local community. The service had responded to the requirements of changing national guidance and expectations by implementing changes and improvements to the end of life care pathway in the hospital.

The specialist palliative care team responded quickly to referrals that were made and ward staff were positive about the support, advice and input provided.

Various information leaflets were available from the palliative care team, the bereavement service and the chaplaincy service. These had recently been reviewed and updated.

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

- During the year 2014 the trust reported there had been 762 deaths in the hospital. Between April 2014 and March 2015 there were a total of 454 referrals made to

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the specialist palliative care team. Over the past five years that had been an increase in referrals to the team of 45%. The team had responded to 80% of referrals within 24 hours.

- Both the Hospital Standard Mortality Ratio and the Standard Hospital Mortality Indicator were reported as 107 as at July 2015.
- The Trust had undertaken local annual end of life care audits in 2012, 2013 and 2014 which included data on patient's achieving their preferred place of dying. The 2015 local annual audit was delayed until March 2016 whilst the Personalised Care Framework was rolled out across the Trust. Staff said that provided there were no problems with funding they could usually get people home if this was their preferred wish'. Data produced by the trust showed that they were 2.6% below or better than the national average for patients dying under their care compared to those who were discharged home. In the trust annual end of life report they reported that the trial of seven day working for the specialist palliative care team had produced some encouraging outcomes around the avoidance of hospital admissions and people being supported in their place of choice. No definitive data had yet been collected around this. The Trust had plans to undertake a further local end of life audit in March 2016 after the complete roll out of the personalised care framework in line with its previous local audits in 2012, 2013, 2014.

## Meeting people's individual needs

- Patients individual wishes were recorded in the personalised care framework documents. This could record their preferred place of dying and any wishes they had for their spiritual needs. We saw examples of patient's wishes being recorded and in some records it was recorded that it "had been discussed with patient" or "patient in agreement".
- Staff tried to accommodate individual needs with the provision of side rooms for patients receiving palliative care though this was not always possible if a room was not available. We were told of one patient who was admitted to hospital whilst their partner was receiving palliative care in the hospice. The staff worked together and provided them with a joint room until the patient passed away.
- There were various leaflets and information available for patients and relatives. The hospice had produced a leaflet entitled "What do I do now" which provided

information and guidance for relatives for what they needed to do following bereavement. Relatives we spoke with said they were provided with all the appropriate information they needed in respect of collecting belongings and making any necessary arrangements over death certificates. Staff had provided the information that was required in a compassionate but timely manner.

- The bereavement office was located next to the mortuary, the whole area being called the bereavement suite. The staff worked closely to ensure that relatives were treated with compassion and received an efficient and professional service. After receiving a deceased patient's notes the bereavement office would wait for the family to contact them but if this had not happened within 48 hours they would make contact themselves. The staff arranged viewings if this was requested and these were done in one hour appointments. If possible staff tried to arrange the viewings to coincide with the collection of the death certificate to minimise the travel and distress for families. If requested the staff would arrange for a member of the medical team to meet with relatives to clarify any issues over what was written on the death certificate. The viewing area was comfortable and well maintained.
- The bereavement suite provided a five day service and viewings could not be routinely arranged over the weekend. We were told that this had rarely been requested. However if a request for weekend viewing was made ward staff had been instructed to escalate the request to the hospital site duty manager. The viewing would then be organised using on call staff. The same process would be used if there was request for a quick release of a body for religious or cultural reasons. However there were some inconsistencies in staff understanding of weekend viewings. Some staff said they understood they could not be arranged while some understood that the request should be escalated and dealt with by the site manager, who could arrange a viewing if this was deemed necessary. The issue of difficulties with weekend viewing was on the trust register as a moderate concern.
- The chaplaincy service provided a seven day 24 hour service with two full time staff, three part time staff and 38 volunteers. The chapel was presented as a multi-faith area with various changes having been made to the lay-out in recent months and some more alterations planned. The chaplaincy staff had consulted with staff

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from different faiths and cultural backgrounds about the most appropriate use of the chapel space. Outside of the chapel was a board where anyone could leave prayer requests or messages. There was also a “prayer tree” located within the main chapel area. The service visited every ward at least once a week. Staff said they always spoke to ward staff first if possible. The chaplains would also undertake follow up visits to patients who had been visited by volunteers if this had been requested. When a patient was identified as being on the end of life pathway, and had a personalised care framework document completed, a member of the chaplaincy staff would visit that ward every day. They would ask the staff if they were required to visit and talk to the patient or their relatives.

- The chaplaincy service had produced a leaflet that was widely distributed through the hospital which promoted the work they undertook and the services they provided. This explained the multi-cultural and multi-faith approach of their service and the links they had developed with other faith networks.
- On the majority of the wards there were quiet rooms available for relatives and some also had a kitchen area that could be used. Some wards had collapsible beds that could be put into side rooms for relatives. Located in the grounds of the hospital was a bungalow that could be used by relatives. The ongoing refurbishment of wards within the hospital contained plans to ensure that every ward would have a designated quiet room for relatives.
- Non traumatic dying patients who were admitted through the accident and emergency department were moved if possible to a side room on a short stay ward. However this was not always possible and some patients had to be accommodated on the ward. When there was a traumatic death a patient was moved into a side room in the department and there was also a family room that was available for relatives. The team accessed the palliative care team for advice and there was also an end of life link nurse in the department. The accident and emergency department had its own dedicated bereavement service. Relatives were phoned after a few days and staff would call again after a further period. Staff could also arrange, if required, for relatives to talk to medical staff.
- When a patient died who had been referred to the palliative care team a nurse from the team would contact the family within one week of the death, after

which they handed over the liaison responsibility to the family support team. If requested they would contact the relatives to answer any questions or meet with them if required.

- Located within the hospice building was a day centre which opened four days every week. This service provided support for patients and respite for some carers. There were also certain days every month when patients and carers attended together. We spoke with patients attending the centre and they were very positive about the resource and how it afforded respite for carers as well as a chance to meet other patients.
- The trust had an open visiting policy for relatives of patients on end of life care. Relatives we spoke with said they were usually offered refreshments by staff or were able to use the kitchen facilities. Concessionary parking was also available to relatives.
- Patients and relatives were positive about the quality of the food provided by the hospital. There was a good range of choice and we were told that it was usually of good quality.

## Access and flow

- The trust had introduced some changes to the process to facilitate rapid discharge home for patients. A planning group had been meeting every month to oversee the action plan that was being implemented. The group had reviewed and updated the checklist for rapid discharge and the paperwork that was provided on every ward. We saw there was an effective working partnership between staff and the discharge team. The working group was also identifying and escalating issues around delayed discharge.
- The trust had a discharge team who were able to organise rapid discharge for patients when requested. They had contact with every ward every day Monday to Friday they were able to organise weekend discharges in advance when requested. The team completed the necessary paperwork and arranged transport, medicines and funding if required. The transport was provided by an external contractor and staff said there were problems every week with delays over transport. There were also occasional delays due to the funding for some community care packages and also due to waiting for equipment to be delivered. We spoke with one patient who had wished to go home but funding had not been agreed for the care package. The records



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showed that discussion had taken place with the discharge planning team. The issue of delayed discharge due to funding shortfalls was identified as a moderate risk on the trust risk register.

## Learning from complaints and concerns

- When formal complaints had been investigated and completed the staff were shown a copy of the reply. There were very few complaints received in respect of end of life care or the palliative care team. There had been three formal complaint made in relation to end of life care in the previous twelve months, two related to the care provided and one to the discharge arrangements around a care package. Staff explained how they were provided feedback from complaints at ward meetings.

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

Requires improvement



We judged the leadership of the service as requiring improvement.

There was evidence of leadership in both in the palliative care team and at board level however there was not a trust wide strategy or policy on end of life care. This was combined with limited representation at the strategy steering group from board members.

An improvement plan was in place for end of life care that was being overseen by a trust wide strategy steering group. The palliative care service had produced its own strategy policy and an extensive educational strategy.

Staff worked in a positive and open culture and felt supported by their colleagues and line managers. Staff felt valued by the trust and were engaged with the trust objectives. Staff were committed and motivated to provide an improving service and embraced the initiatives that were being developed by the end of life steering group.

## Vision and strategy for this service

- There was an improvement action plan in place for end of life care. This was initiated following the results of the National Care of the Dying Audit that was completed in 2014 and also to respond to and implement national

directives such as the National Institute for Health and Care Excellence (NICE) Quality Standard on End of Life Care. The action plan was being audited and benchmarked against trust objectives.

- The Salisbury Palliative Care Service had produced a five year strategy and business plan that ran from 2012 to 2017 and also an education strategy that ran from 2015 to 2020. Both these documents stated a clear vision for the future of the service in terms of aims and objectives. Since October 2010 there had been an end of life steering group in place that met bi-monthly. This group was overseeing the improvement action plan for end of life care and the various developments, initiatives and changes that were being implemented following the ending of the use of the Liverpool Care Pathway. They also ensured the service moved in line with national developments and guidance. One recommendation has been that there should be board level leadership on end of life care. The medical director for the trust had the responsibility for this, and was the board representative on the steering group. However they had been unable to attend the majority of meetings due to other commitments. They liaised with the other senior managers who attended this group, including the manager for clinical effectiveness. Whilst the steering group was overseeing a range of positive changes and improvements, there was not yet any trust wide policy or strategy on end of life care that over-arched all this work. The leadership and direction for end of life care in the trust came primarily from the specialist palliative care service. This was a role the service had fulfilled for number of years due to the size of the Salisbury Hospice Service and its prominent role in the hospital. The medical director acknowledged that a trust wide strategy was needed and that this would further promote the message that end of life care was “everyone’s business” and also allow more hospital ownership of end of life care.
- The palliative care service strategy and business plans were detailed, comprehensive documents that covered a range of areas, including the new end of life pathway and also proposals for the community service. The managers of the palliative care service were supported by the trust board and the strategy group but were keen for a trust wide strategy and policy to be in place. This

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additional strategy would help the service share some of leadership of end of life care and improve the future service by increasing the impetus of the changes being implemented.

## Governance, risk management and quality measurement

- There was a structure for governance reporting and risks were identified and understood by the palliative care team.
- The strategy group met bi-monthly and reported back to the board on the progress of the improvement plan. A review of the progress of the improvement action plan had been undertaken in January and September 2015 and had been fed back to the Board through the Clinical Governance Committee'. This included risk ratings against the key performance indicators. A full report on end of life care was being completed annually and submitted to the board and the clinical teams. We saw minutes from the Trust Clinical Governance Committee from February 2015 when members of the palliative care team presented an update on end of life care in the trust.
- The palliative care service was part of the medical directorate of the trust and accountable to the wider trust management structure for operational planning. The hospice service was also linked to a charity, The Salisbury Hospice Charity that provided over 50 % of their running costs. The hospice had an executive board with representatives from the trust senior management, Salisbury Hospice Charity, palliative care clinical leads, NHS Wiltshire and the local commissioning groups. The executive board agreed developments and held the service to account for the delivery of their strategic plan.
- The strategy group included a wide range of staff and also two representatives from the governors of the trust.
- The palliative care team escalated concerns to the trust risk register. At the time of the inspection there were seven entries on the register. These included identified risks around an unreliable electronic data base, the difficulty of arranging mortuary viewings at weekend and the possibility of losing funding for the seven day working pilot. The register identified the group responsible for reviewing risks and where possible the staff responsible for taking action and the required timescale.

## Leadership of service

- The trust had an end of life steering group that met every two months. This group was overseeing the various improvement plans that were in place to support the work towards meeting the five priorities of care for end of life, and also to the meeting of the NICE end of life guidance. The medical director had taken on the board responsibility for end of life care and there were also two governors on the steering group. Other senior medical, nursing and managerial staff were also part of this steering group.
- Staff within the palliative care team were very positive about their leadership and the support and encouragement the senior managers and consultants provided. Staff said they felt able to approach managers for advice and there was an open culture where issues and concerns could be discussed.

## Culture within the service

- Staff all spoke of the supportive and open culture they worked in. Nursing staff said they often saw the director of nursing and chief executive of the trust who would come onto the wards and speak to staff and patients. Staff said they felt valued as members of their immediate team and the wider trust. Staff spoke positively about the trust as a workplace that was friendly, and also supportive of staff that may have personal concerns outside of work. Staff said they were proud to work at the hospital and proud of the good reputation they felt it had in the local community.
- Two band 7 nurses who had started work at the trust within the last six months said the support when they started from all the staff on the wards had been excellent. They were also well supported by the director of nursing through this period.

## Public engagement

- The chaplaincy service had organised a meeting with a range of people from the community from different faiths to discuss the different views around organ donation. They were in the process of planning another meeting where end of life issues could be discussed more broadly. The hospital had also hosted two events arranged by local community initiatives called 'grave matters' and the 'death café'. These were designed to encourage patients, relatives and staff to attend and talk about death and dying.
- The bereavement service had undertaken a survey of bereaved relatives in June 2014 and we saw the results

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and report from this work. The feedback was positive with comments about the ease of the process and also some suggestions around signage which the team had acted upon. One relative expressed their gratitude for their relatives “last days and their aftermath were so greatly eased”.

## Staff engagement

- The hospice conducted its own staff survey annually and provided the feedback to all the different teams working there.
- The chaplaincy service had met with the staff representative from the trust’s Black and Minority Ethnic support group to discuss suggestions to improve their multi-faith and multi-cultural services. One outcome was the service will be in future broadcasting information about all the different religious and cultural festivals throughout the calendar year.
- Information was provided to the staff through a regular trust newsletter and also from email updates from the chief executive.







## Innovation, improvement and sustainability

- Along with other stakeholders a business case has been put forward to commissioners for the development of a

“hospice at home” service. If successfully implemented this would have an impact on the ability to discharge patients more easily into the community and also help with admission avoidance.

- The hospice had started having Schwartz rounds every two months. These are an internationally recognised method for staff from all disciplines to discuss difficult emotional and social issues arising from patient care, and championed by the Kings Fund in the UK.
- Staff in the hospice had started running a “Carers Skills Course”. This was for relatives and friends and was aimed to empower informal carers of patients who wished to be cared for at home.
- The accident and emergency department had set up their own bereavement service that had been successful. This model was now also to be piloted in the medical admissions unit.
- The trust was taking part in a research project with the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) and University Hospital Southampton which was looking at the development of a treatment escalation plan (TEP) which would include a DNA CPR form that was used nationally.

# Outpatients and diagnostic imaging

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

## Information about the service

Salisbury NHS Foundation Trust provided diagnostic services at Salisbury Hospital. These included a range of general and specialist imaging procedures including plain X-rays, CT, MRI, Nuclear medicine and ultrasound. The department is supported by a GP and Spinal x-ray unit. The department is also responsible for providing x-ray services at three community locations in Shaftesbury, Fordingbridge and Westbury. In the year 2014 to 2015 the department performed 170,539 procedures.

The trust served a local population of 240,000 (across Wiltshire, Dorset and Hampshire) and saw over 188,000 outpatients in the year 2014 to 2015. The trust also had extensive links with the Ministry of Defence to provide outpatient and diagnostic services to military personnel and their families. On average the outpatient departments received over 7000 referrals each month from within the hospital, other local hospitals and GPs. For new appointments this accounted for 33% of all appointments compared to a national average of 25%. The majority of appointments at Salisbury were follow up's (61%) compared to a national average of 55%.

During our inspection we visited the main outpatients department for medicine and surgery. We also visited the vascular, rheumatology, ear nose and throat (ENT), orthopaedic, eye, breast, fracture and plastics clinics. We visited the diagnostic department including general radiology and nuclear medicine. We spoke with 49 patients

and 28 relatives/carers. We also spoke to 42 members of staff including managers, clinical (doctors, nurses, allied health care professionals and health care assistants) and non-clinical staff.

# Outpatients and diagnostic imaging

## Summary of findings

Salisbury NHS Foundation Trust outpatient and diagnostic services were overall rated as good.

There were good systems in place for incident reporting and learning from when things did not go as planned. Systems were in place for the safe administration of medicines and for the prevention of infection. The outpatient and medical records department achieved a high standard in making sure medical notes were available for 99.91% of appointments. Staff were knowledgeable about safeguarding and their responsibilities to vulnerable adults and children. During our inspection we observed an emergency situation in the outpatients department. The way in which this was handled showed staff were aware of the health of their patients and responded quickly and appropriately to any deterioration in a patient's health.

Staff were very competent in the roles they were being asked to perform. There were some outstanding areas of practice including the nurse led pathways within the rheumatology outpatients clinics and one stop clinics within urology outpatients. There was good multidisciplinary working both within the trust and with other external organisation such as other health care providers and the Ministry of Defence.

Staff communicated in a professional but friendly manner with patients and their families. Comments from patients and relatives were very positive about the staff and how they provided their care and treatment. Patients were involved in their care and treatment and always put them first.

The departments provided a good service to make sure people were not waiting long periods of time for either outpatients or diagnostic services. The trust was working with other local hospitals and looking at capacity demand in order to make sure waiting lists did not increase. We saw that the trust was achieving 92.94% for its cancer two week waiting time against a standard of 93%. The follow up appointment is agreed between the patient and clinician, within an agreed timescale. The patient is then put onto a waiting list and this is noted in the consultation letter to the GP. The patient is monitored and booked immediately if they

ask for a follow-up, or discharged if they choose not to have a follow-up appointment. We saw evidence that complaints were discussed at departmental meetings and changes were made where necessary to help prevent further complaints.

Staff were supported at all levels from their immediate manager through to the trust executive team including the chief executive. Good governance systems were in place across outpatients and diagnostics. Whilst some staff described the culture as a 'them and us' we did not see this view shared by the majority of staff. The majority of staff we spoke with felt the culture was open and that staff strived to make sure the experience for patients was outstanding in line with the trust vision.



# Outpatients and diagnostic imaging

## Are outpatient and diagnostic imaging services safe?

Good



We rated the safety in the outpatient and diagnostic imaging service as good.

There were systems in place that supported staff in protecting patients from patients experiencing avoidable harm. This included reporting incidents when things did not go as planned. Incidents were discussed at governance meetings and changes put in place where necessary to prevent similar incidents from taking place. Other systems in place included measures to prevent the spread of infection, the safe administration of medicines and maintenance of equipment.

Staff were knowledgeable about safeguarding issues relating to both adults and children. Staff were encouraged to complete their mandatory training and we saw evidence that the majority of staff in outpatients had completed their mandatory training. Within radiology plans were in place to make sure staff completed their training as quickly as possible.

Staff responded well to any deterioration in a patient's condition. We observed staff dealing with an emergency situation which showed staff knew their roles and responsibilities not just to the patient concern but the other patients in the department and each other after the emergency.

### Incidents

- We looked at the incident reporting system used by the radiology department. This showed us that between April to June 2015 staff reported 25 incidents. These ranged from water leaks affecting the department (four), equipment failures (two) and errors made because referrals were not read properly (five). In outpatients, 115 incidents had been recorded between April and the end of July 2015. All of these incidents had actions against them where appropriate.
- Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses. Staff across both outpatients and diagnostics were fully aware of the incident reporting procedures and told us they would have no hesitation in reporting an incident.

We saw evidence that staff did report incidents. Staff told us that they were always encouraged to report incidents although they did not always received feedback on the outcome of the investigation.

- Lessons were learnt, action taken and this shared to improve safety for patients. Incidents were discussed at departmental meetings and where necessary via peer review meetings. We saw evidence that incidents were discussed and that learning took place as a result. As an example, the ultrasound scheduling was changed so that the monographers had access to radiologists during their lists for advice and support.
- There had been two IRMER (Ionising Radiation (Medical Exposure) Regulations 2000) incidents where the patient had been exposed to more ionising radiation than was recommended. These incidents were reported to the radiation protection link and to the radiation protection committee.
- Duty of Candour had been introduced to staff. All the staff we spoke with in the outpatients and diagnostic departments were aware of the Duty of Candour and their responsibilities to be open with patients when things did not go as planned. From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to incidents or harm categorised as 'notifiable safety incidents'. We saw evidence that the Duty of Candour had been followed in an incident that took place prior to our inspection. The patient had been provided with apologies and explanations.

### Cleanliness, infection control and hygiene

- There were reliable systems in place to prevent and protect people from a healthcare-associated infection. During our inspection we found all the areas we visited to be clean and tidy. Cleaning audits (patient led assessments of the care environment (PLACE)) had been completed regularly across all outpatient and imaging areas. Within these audits, areas were checked against quality standards and given a rating of pass, qualified pass or fail. We looked at the results for 20 separate areas all of which had passed.
- We observed hand washing practices being implemented before and after patient interactions. All the staff we observed adhered to the Trust's infection prevention and control policy by observing 'bare below the elbow' rule.

# Outpatients and diagnostic imaging

- Information was displayed on the hand hygiene audits that took place across the different outpatient departments. A number of departments consistently scored highly achieving 100%. These departments included Vascular / diabetes, medical / surgical, ENT, eye, oral surgery, rheumatology and dermatology clinics. The plastics clinics did not score as highly. In June 2015 the plastics clinics achieved 86.36%. In August, the radiology department achieved 94.74% for its hand hygiene audit.
- Toilet facilities were located throughout the outpatient and diagnostic imaging areas and clearly signposted. We found these to be clean. Housekeeping staff were available throughout the day to provide additional cleaning facilities as necessary.
- Personal protective equipment such as aprons and gloves were available in all the radiology and outpatient departments. We observed staff using this appropriately and where necessary.
- During our inspection we observed an emergency situation. We saw that all the staff involved wore gloves appropriately. Following the situation, the staff worked in conjunction with the cleaning staff to clean the area appropriately so that it could be brought back into action for other patients as quickly as possible.
- Cleaning schedules were in place across the outpatients and radiology departments. Linen skips were available in radiology which reduced the risk of cross infection because staff did not have to carry dirty linen along the corridors. Special sealed boxes were in place for the disposal of sharps, we saw that these were sealed and signed appropriately. Systems were in place for the safe removal of these boxes from the hospital.

## Environment and equipment

- Systems were in place to ensure the use and maintenance of equipment prevented avoidable harm to patients. Equipment was maintained according to manufacturer's instructions. Equipment was also tested for electrical safety. Stickers on each piece of equipment showed when they were tested and when they are due to be tested again.
- Emergency trolleys and bags were available in both radiology and outpatient areas. These trolleys were tamper proof by means of security tags. The trolleys and bags were checked on a regularly basis and we saw evidence to confirm that these checks took place. Each emergency trolley had an emergency medicines box

that had already been checked and sealed by the pharmacy department. If the seal was broken, staff would return the box to pharmacy and receive a replacement. During our inspection we observed an emergency situation in one department. Following this emergency, the emergency trolley was cleaned and restocked by the staff before being resealed ready for use again.

- None of the outpatient or radiology waiting areas we visited had separate waiting areas for children. There was a dedicated children's outpatients department which did see children from a number of specialties. In the main outpatient areas, there was a selection of toys for different age groups available and systems were in place to keep them clean and in a safe condition. We did see evidence that some outpatient areas such as eye held dedicated children's clinics so there would not be adult patients in the waiting area at the same time.
- Staff in radiology had access to specialised personal protective equipment for use within areas that were exposed to radiation. We observed staff using this equipment appropriately. Staff wore personal radiation dose monitors which were monitored according to the national legislation.

## Medicines

- The outpatients and imaging departments had arrangements in place for managing medicines which kept people safe.
- Where necessary outpatient departments had systems in place to review the prescription of high cost medicines. As an example, within one specialty it was routine to prescribe expensive medicines to patients with chronic conditions. Patient receiving this medicines were closely followed up to monitor the effectiveness of the medicines. Following this review, doses could be increased, decreased or stopped altogether. This made sure patients were on the correct medicine for their individual needs. It also meant the department and the trust was using the medicines in a cost effective way.
- We looked at how medicines were stored in radiology and a selection of outpatient departments. We found that medicines were stored appropriately in locked cupboards that only staff had access to. Where necessary fridges were available. The temperatures of these fridges were checked on a daily basis to make sure the medicines were being stored at the correct temperature. We reviewed how controlled medicines

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were stored, and found that these were locked away separately and checked by two members of staff and recorded in a dedicated controlled drug book. We did not see any medicines that were stored inappropriately or that were out of date.

- The outpatients departments kept stocks of two different prescriptions for the medical staff. The majority of medicines were prescribed on the 'in-house' prescription sheet that patients could take to the hospital pharmacy. External prescription forms were also kept that could be taken to any outside pharmacy. All the prescriptions pads were kept secured in locked cupboards that only the nurse in charge had access to. The audit systems in place for the external prescription forms were not robust enough to make sure they were not being used inappropriately because they only recorded the patients' name. We raised this with the manager who told us they would improve the system across the outpatients departments. The following day, the manager showed us the system they had already implemented. We found this to be appropriate to adequately record and audit the prescription forms.

## Records

- People's individual care records were written and managed in a way that kept people safe.
- The outpatients departments monitored how often patients were seen in clinics without their medical records. From January to July 2015 123,548 sets of patients notes were needed for the various clinic appointments across the trust. Out of these, 115 sets of notes could not be located for the appointment. The department identified that this was because the notes had been miss-filed, staff had not used the case note tracking properly or the notes were off site for another appointment. Overall, patients' medical notes were found for 99.91% of appointments, which was a small increase from the previous two years. This showed that there was an effective system in place for making sure patients' medical notes were available for their outpatient's appointments. Where they were not available, a reason was identified to try and reduce the likelihood of the issue happening again.
- Staff told us that the medical records department provided a good service. Staff found requesting notes easy for both routine appointments and last minute appointments. We observed staff following trust procedures for requesting and tracing notes.

- We looked at four sets of medical notes within the surgical outpatients and two sets of notes in the eye clinic. All the notes had a confidential cover to prevent other patients and members of the public seeing patients name and address. The notes were filed correctly and the entries from outpatients were dated and signed appropriately. Entries were legible and contained information gained at the appointment together with the future plan.
- During clinics, notes were stored at the nurse's station however, they were not locked away. A front 'confidential' cover was placed on each set of notes so that other people could not see any patient details. Outside of the normal clinic times, the notes were secured in the clinic area which was then locked to the general public.
- Patients were able to check in to their appointment when they arrived at the department either via the reception desk or by using a self-service check in kiosk. These kiosks were touch screen computers where patients could input their details to check in for their appointment. The screens for these kiosks were visible for every angle and therefore did not always protect people's confidential information if several patients were queuing to check in. The patients we spoken with during our inspection told us they had no concerns using the kiosks and they had the option of using the reception if they choose to.

## Safeguarding

- The staff we spoke with in both outpatients and diagnostics understood safeguarding for both adults and children. Staff were aware of their responsibilities to report and document safeguarding concerns and would have no hesitation in doing so. Staff knew who the safeguarding leads were, and where they could turn for further help, support and/or advice.
- Where children failed to attend for their appointments, the child's GP and where necessary other professionals would be contacted to make sure there were no concerns.
- There were systems, processes and practices in place to keep people safe and these were communicated to staff. Training records for radiology showed that 87.39% of staff had completed the safeguarding training for adults. For children's level one safeguarding 87.50% of staff had completed it and 75% of staff had completed level two. This was against an overall trust target of 85%.

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Within outpatients, all staff had received training in the safeguarding of adults and children. All clinical staff within outpatients had received training to level two in children's safeguarding.

- Any safeguarding concerns were documented in the patients' medical notes. We were told that the staff were always on the look-out for specific issues that individual patients might have.

## Mandatory training

- We looked at training records for the radiology department. These showed that not all staff had completed their mandatory training. The majority of the training was provided via e-learning. The department scored had not met the trust target of 85% in the following areas: equality and diversity 76% fire training 74%, infection control 81% for information governance 77% and moving and handling training 72%.
- We looked at the training records for the outpatients department. These showed that the majority of staff had completed their mandatory training. The records showed that 100% of nursing staff had completed their equality and diversity, fire safety and safeguarding training. The majority of other training such as infection control, information governance and resuscitation had been attended by a large proportion of staff and plans were in place to make sure all staff achieved 100% compliance.
- Staff in both departments told us that they felt the mandatory training was of a good level to ensure the safety of patients.

## Assessing and responding to patient risk

- We saw examples that staff were aware of the patients in their areas and what to do in an emergency or if a patient was feeling unwell. Staff knew how to contact the resuscitation teams and knew where the emergency equipment was kept within their own areas. As an example, during our inspection a patient felt unwell during their scan. They were monitored by the radiology staff before being moved to a more appropriate area for further review. The staff monitored the patient closely, whilst also looking after the relatives.
- During our visit to outpatients, we observed staff dealing with an emergency situation with a patient. The staff recognised the emergency straight away and responded immediately. Some staff immediately

attended to the patient whilst others cleared the waiting area of the other patients. Help was summoned from the trust's emergency response team. Staff were calm and professional in dealing with the emergency.

- Radiology used an adapted WHO surgical safety checklist for all radiological interventional procedures. We checked six of these checklists and found them to have been completed appropriately. Audits were completed with very positive results. As an example, out of 40 patients that were reviewed in one audit, all of them had the appropriate checks carried out.
- Any imaging requests for women included pregnancy checks to make sure staff were informed of any possible pregnancy before exposure to radiation.

## Nursing staffing

- An outpatient nursing consultation (led by the Director of Nursing) ran from July to the end of August 2015 and recommended a new leadership structure for the department. At the time of our inspection, the trust had implemented the first recommendations of this review. A nurse manager had been appointed to lead the whole outpatients department. The second recommendation was to review the staffing requirements using the baseline taken in 2012 as a starting point. Prior to our inspection a consultation took place in July and August 2015. This consultation confirmed the overall nurse manager lead followed by a detailed review of the band six roles in the outpatient areas.
- The current staffing for outpatients is made up of 63.71 WTE. As part of the outpatient nursing consultation this was planned to reduce to 54.64 WTE. The reduction would come from the qualified nursing staff, but increasing the band two health care assistants to support the various clinics. At the time of our inspection the departments were fully staffed.
- At the time of our inspection, a number of outpatient departments were operated separately. We were told plans of how this would change to bring all outpatients departments under one nursing manager.
- Plastics, oral and maxillofacial and orthodontics outpatients did not use any acuity tools to decide staffing levels. Staff told us that they would regularly review the nursing staffing levels based on their clinic workload. Staff we spoke with during the inspection told us that whilst they would always like more staff, the current staff numbers were sufficient to meet demand.

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- The clinic staff rotas were staggered during the day to make sure there were staff throughout when clinics are operating. This extended into the evening for some clinics such as ear nose and throat.

## Medical staffing

- Information provided by the trust prior to our inspection showed the staffing establishment for radiology was:
  - Radiologists 13.30 WTE
  - Band 8a nursing / managers 4 WTE
  - Band 7 Radiographers/sonographers 11.73 WTE
  - Band 6 Radiographers 12.67 WTE
  - Band 5 Radiographers 22.64 WTE
  - Band 4 assistant practitioners 2 WTE
  - Band 2 radiology department assistants 10.80 WTE
  - Administration team 20.35 WTE
- The medical staff within the diagnostic imaging department had rotas in place to show which radiologist covered radiology, ultrasound, MRI etc. Rotas were in place for on-call work which included weekends and nights.
- The trust had experienced difficulties in recruiting radiographers in the six to 12 months prior to our inspection. This had been covered by existing staff working additional hours and the use of agency staff. At the time of our inspection the department had four whole time equivalent vacancies for radiographers. A recruitment plan was in place and the vacancies had been identified as a risk on the risk register.
- The medical rota for radiology was produced six weeks in advance with the aim to have a minimum of four radiologists on site each day Monday to Friday between 9am and 8pm. The rota's we looked at confirmed this was achieved.

## Major incident awareness and training

- Staff we spoke with were aware of the major incident policy and the action cards that related to their department. The action cards were kept in the accident and emergency department and copies were also kept in the radiology department for easy referral by staff.

## Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

The effectiveness of outpatients and diagnostic was not rated due to insufficient data being available to rate these departments effectiveness nationally.

The use of best practice was evident throughout the outpatients and diagnostic imaging services. Staff felt their training was good and provided them with the necessary skills and knowledge to perform their role. Systems were in place to assess competencies both in a department and for specific pieces of equipment.

Multidisciplinary working was in place to ensure efficient patient care. Staff worked in partnership with other hospital departments, external health care providers and other organisations such as the Ministry of Defence. Diagnostic imaging was available seven days a week to inpatients within the hospital. The outpatient department provided evening and weekend clinics in some specialities and was looking to increase this to improve availability for patients.

## Evidence-based care and treatment

- We saw evidence that policies and procedures were evidence based where appropriate. As an example the pathway for breast cancer was followed by the breast care team. This pathway was based on the National Institute for Health and Care Excellence (NICE) guidelines for the diagnosis and treatment breast cancer.
- The radiology department had comprehensive examination protocols which were available to all the radiographers. These were audited on a regular basis which showed staff were compliant with the protocols.
- Clinical audits were undertaken, these included audits as required by IR(ME)R. The results of these audits were shared at staff meetings.

## Patient outcomes

- A liaison service had started within rheumatology outpatients in November 2015. This service looked at patients with low trauma fractures specifically for signs of osteoporosis. Once patients were identified they were offered a specialist DEXA scan (Dual Energy X-ray Absorptiometry - a special type of x-ray that measured bone mineral density). The staff liaised with the patient and their GP and started treatment where necessary. Where osteoporosis was not identified, the staff would



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look at prevention with each patient. Helping to prevent the condition through lifestyle choices and preventing further fractures. Audit arrangements were in place to monitor the effectiveness of the service. At the time of our inspection the service was too new to show any benefits. Staff told us that over time the service would improve mortality by identifying the condition early, starting appropriate treatment and reducing the chance for further fractures.

- We saw nurse led pathways being used. In one example a nurse led pathway was in place for early arthritis. This pathway had been ratified by the Royal College of Nursing. National best evidence showed that patients would go into remission earlier if they were diagnosed quickly and started on the appropriate treatment. The pathway was based on this good practice. This service came top in a national audit for patients with early arthritis. The staff had presented their service at national and international conferences including the Bristol Society of Rheumatology conference in 2015. When the service was audited it was found to be fully compliant in the majority of areas. One action was required following the audit. The action from the audit was to make sure the nursing team were aware of the time frame of making referrals. This action had been completed prior to our inspection and a re-audit was planned in 2016.
- Within the rheumatology clinics, patients on biological therapies (biologics, newer and expensive medicine therapies) were seen in one stop clinics. They could get an ultrasound if necessary which helped the doctors and nurses explain how the therapies were working. Patients were able to see on the screen the effect or not of the medicines. This meant that the staff were able to finely tune the medicine therapies which reduced unnecessary waste and cost. Since this service had been introduced, staff had been able to reduce the medicine dose for 15 patients and stop it all together for eight patients. Four patients were also able to be switched to more appropriate medicines for their particular condition. At the time of our inspection, staff were collecting additional data to show the benefits to patients and a cost improvement in medicines prescribing.

## Competent staff

- Information provided to us by the trust before our inspection showed that 73% of radiology staff had

received their appraisal at the end of June 2015. We asked why the figure had not met or exceeded the trust target of 85% and were told there had been a delay in senior staff receiving their appraisals. We were told senior staff needed to agree their objectives before appraising junior staff. The appraisals for nursing staff within outpatients and radiology department was 99%. The appraisals were linked to the trust values. Within outpatients, the manager carried out the appraisals of the band five's and six's who in turn did the appraisals for the band two's and three's.

- Radiology especially used a lot of different and very specialist equipment. Training records were in place for each member of staff. These records showed which equipment that member of staff had been trained to operate safely.
- Staff in both the outpatients and imaging departments had received a trust induction and local departmental induction. For imaging staff, this also included the accident and emergency department. When new staff started, they received a welcome pack, where able to shadow more experienced staff and complete competency checklists before working alone. Staff were able to rotate between different areas within their areas of work.
- We looked at the training records for six radiology staff and found them to be complete and comprehensive. The records showed that the staff had received a departmental induction, together with an induction to the accident and emergency department. Staff then received a six month preceptorship programme during which time competencies were assessed and signed off. Staff were assessed on their competencies for general radiology skills and specific pieces of equipment.
- Competency documents were used in other areas such as rheumatology outpatients. The documents were comprehensive and covered the individuals' skills and knowledge in a particular area. Where necessary the competencies were based on national evidence and professional regulations.
- The staff we spoke with felt the induction both trust wide and departmental was effective and prepared them for their role. Staff were encouraged to complete additional training depending on their role. As an example, one member of staff told us they were training to be a scrub nurse within radiology.

## Multidisciplinary working

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- There was good evidence of multidisciplinary working within radiology and outpatients. They worked with every department across the trust. As an example radiology supported 24 multidisciplinary meetings. Radiologists and directorate managers also linked very closely with neighboring trusts and other colleagues within the South West and South Central regions.
- The bookings team regularly involved the relevant consultants in the state of their waiting lists. The booking staff felt this was important in gaining their co-operation in bringing the waiting lists down. The booking team also liaised closely with the theatre booking team. As an example if a particular surgeon needed to do more operations, it would be discussed with the outpatients booking team to make sure it would not impact on the consultants clinics.
- We saw examples of where staff worked across organisational boundaries such as with the prison system and the Ministry of Defense (MoD). As an example, the hospital provided services to a large number of military personnel and their families. The outpatient and radiology staff would liaise directly with the MoD's family medical centres to make sure they received the care they needed.
- Other examples of good multidisciplinary working where seen within the one stop clinics where allied health care professionals, nurses and consultants from different specialties came together in one clinic to see the patient.

## Seven-day services

- The radiology department provided a 24 hour a day x-ray service for the emergency department, wards and theatres. The majority of the other services were predominately open from 9am to 5pm Monday to Friday. Outside of these hours, duty radiologists and on-call radiographers were available outside of those hours so that patients had access to urgent imaging. Radiologists were on site on Saturday and Sunday mornings for urgent scans and reporting results.
- Outpatient clinics were provided Monday to Friday from 8.30am to 5pm. Some of the specialties operated evening and Saturday clinics and this was being extended to include more specialties. The oral outpatients operated an on-call service during the evening and weekends so that emergencies could be seen following referral from the accident and emergency department.

## Access to information

- All clinics and wards had access to the electronic imaging system. This meant that X-rays and scans could be viewed on computer systems throughout the hospital.
- Overall, patients' medical notes were available for 99.91% of appointments. Therefore appropriate information was available for the consultation with the patient

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

- Staff within the outpatients and radiology departments told us they had received training in the Mental Capacity Act. This was confirmed in the staff training records. Staff were aware of their responsibility surrounding patients consent.
- We observed staff seeking patients consent for general care and treatment. Where specific procedures took place, we saw that consent had been taken by a doctor and the consent form filed in the patient's medical notes. The patients we spoke with confirmed that the doctors had explained the procedure, and risks and benefits before asking them to sign a consent form.

## Are outpatient and diagnostic imaging services caring?

Good



We judged the services provided to patients by the outpatients and diagnostic imaging departments to be good.

Staff communicating well with patients of all ages, treating them with dignity and respect. Staff were kind and compassionate and patients had no complaints with the care they received.

Patients were involved in their own care and treatment, carers and where necessary relatives were also involved. Staff provided good support to patients and tried their best to resolve any issues a patient might have. Some outpatient departments had access to specialist psychologist and counselling services for patients.

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## Compassionate care

- We observed that staff in both outpatients and diagnostic departments spoke appropriately, professionally and kindly to patients. Staff listened to what patients had to say and tried to make sure the trust values were adhered to.
- Comments from patients in the outpatient areas included: "The rheumatoid arthritis clinic is very well organised, the attention given to patients is excellent. I feel that I am not just a number, but an individual that needs their help" (rheumatology clinic).
- We received very positive feedback from patients and relatives visiting the diagnostic imaging departments. Comments included "I have always been treated well". "All the staff are so friendly, I've been to most of the hospitals around here, but this is the best". "Booking the scan was very easy, a very good experience". "The staff are kind and explained things very well, they were invested in me as an individual".
- Comments from patients visiting the outpatients department included "excellent service". "Staff are fantastic and friendly". "The department is brilliant". "I can only praise the staff, I can't fault it, I've had perfect care". "The staff were very understanding and supportive". "My appointment time was changed with no reason given, but I have been treated well". "This is my sixth appointment now and I've never had one cancelled, the staff are excellent and I am happy with my treatment". "The staff are kind and very nice to me". "My wife and I have only had positive experiences here, never had to wait long".
- The culture within the outpatients departments was very open and it was obvious that staff treated patients as they would like to be treated. A member of staff told us "it's our job to put people at ease" and we saw evidence of this during our inspection.

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

- Staff understood and involved patients in their own care. As an example, the clinical nurse specialist clinics within rheumatology looked at the whole patient. To do this they helped educate each patient into their condition, medicines and self-care. Counselling was also provided to patients where necessary. Staff told us that

they had increased the number of patients who were compliant with their treatment plans. This in turn had reduced the number of problems that patients had experienced.

- Patients told us that staff discussed and involved them in their own care and treatment. Relatives were also included where appropriate and where the patients consent had been given.

## Emotional support

- We saw evidence that staff provided initial emotional support where necessary. Some of the more specialist teams such as breast care had psychologists included in the team or had access to counselling services. We saw some excellent support given to patients when they were in a vulnerable position. As an example, we spoke with a patient who had turned up for an appointment and x-ray following an injury a few days prior. During their admission for the injury, the communication had been poor from the ward which left the patient extremely upset over the treatment for their injury and possible prognosis. The patient had been instructed to turn up for their appointment, but when they arrived, no one was expecting them because the ward had not notified the outpatient department. This experience left the patient with decreasing levels of confidence in the hospital and worried about the outcome of their injury. When the fracture clinic health care assistant heard this, they immediately organised an x-ray and for the patient to be seen by the specialist registrar. Notes were obtained and support provided to the patient and their relative. The next appointment was made prior to the patient leaving the department to prevent any further confusion. The actions and support of the staff helped the patient to regain some of the confidence in the hospital and they left happier and more positive than when they arrived.
- We observed staff being very supportive to patients during an emergency situation in the outpatients department. Staff moved waiting patients away from the emergency into another department and made sure they were ok. Staff remained on hand to look after those patients, answer any questions they might have and provide reassurance where necessary.

**Are outpatient and diagnostic imaging services responsive?**

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Good



We rated the responsiveness of the outpatients and diagnostic imaging services as good.

Overall, we found that the outpatients and diagnostic imaging services were meeting or very close to meeting their targets on waiting times. In July 2015 only 67 patients out of 3,934 waited longer than the six weeks for diagnostic procedures. For outpatients, the trust was meeting its referral to treatment time targets. Once patients arrived at their appointment, 86% of them waited less than 30 minutes to be seen.

One stop clinics were held in a number of departments which meant patients could have their consultation and any diagnostic tests in the same appointment. Other services were available depending on the patient needs. For example a telephone advice line was available for rheumatology patients and a GP walk in service was available for patients needed x-rays from the GP.

Complaints were discussed at departmental meetings there was evidence that the departments learnt from complaints and put measures in place to prevent similar issues happening to other patients. Staff always tried to resolve concerns that patients had at the time rather than wait for a complaint to come in.

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

- Some patients were concerned at the cost of car parking especially the additional charges if their appointment over ran. We saw signs in place across radiology and outpatients telling patients not to worry if the clinics were running late, they would not be charged any more.
- Outreach clinics were provided in some specialties. These provided services nearer to people's homes and made sure they did not have to come to Salisbury hospital.

## Access and flow

- At the time of our inspection, the trust was achieving 92.94% for its two week cancer wait against a standard of 93%.
- One target within radiology stated that patients should not wait more than six weeks for their diagnostic

procedure. We looked at the figures for July 2015 which showed us that during the month 3,934 patients had diagnostic procedures carried out. The majority of these patients, 82.8% were seen within four weeks, 15.4% of patients waited between four and six weeks.

- Another target was for patients attending their GP with suspected cancer to the time they are treated was 62 days. The standard for all nine areas (breast, colorectal, gynaecology, haematology, head and neck, lung, skin, upper gastro intestine (GI) and urology) was 85%. The trust consistently achieved higher than this standard in the majority of areas. In October 2015 the trust exceeded the 85% standard in seven of the areas, but failed to achieve the standard in lung and upper GI. Overall the trust achieved 86.67% and 88.24% respectively for the 62 day screening target against a standard of 90%.
- The mammography scanner had been out of action since a flood in the department. This had an impact on the women using the service because they had to attend a hospital in Southampton to have a wire inserted prior to breast surgery.
- Salisbury NHS Trust had a lower number of patients who did not attend their outpatient appointments at 6% compared to an England average of 7%.
- We saw figures from April to August 2015 which showed 82,489 patients were seen in the outpatient department. 70,847 (86%) of those patients waited 30 minutes or less once they arrived at their clinic. Those patients that waited between 30 minutes to one hour amounted to 9,416 (11%) and those waiting over an hour were 2,226 (2.6%). This did not take into account those patients who arrived early for their appointment. We saw that staff within outpatients were documented the arrival time of patients, what time their actual appointment was and when they were called for their appointment. This meant the staff were aware of the importance for accurate waiting time figures to improve the waiting times for patients.
- Audits had been completed to find out more about delays to appointments. As an example, in August 2015 the ultrasound department carried out an audit on how long patients waited above their allotted appointment time. The audit looked at 125 patients and found that 45 of those were not seen within 10 minutes of their appointment time. The standard the department set themselves was 90% of patients be seen within 10 minutes of their appointment time. The audit

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highlighted that of those patients that waited longer than 10 minutes; the main reasons for patients waiting more than 10 minutes were portering issues, patients arriving late and over running of maintenance. The department made changes to the patient letters emphasising the importance of being on time, more porters were allocated and additional staff were allocated to the department. A re-audit was planned for 2016 to see if the changes had been effective in reducing waiting times for patients.

- One stop clinics were held by the breast care service three times a week. The service saw 4500 patients each year and consisted of radiologists, consultants, psychologist and specialist nurses. The patient would see the consultant and be examined and then have the necessary tests/biopsy with the results discussed at the multi-disciplinary team meeting within a week of the patient being seen. If the result was positive the patient would be seen in pre-assessment where all the necessary information and support would be given. A wide range of information was available for the women, as well as a specialist illustrated book called 'mummy's lump' which was aimed at children and explained what their mother was going through. The team had been very proactive in providing the service to women and worked in conjunction with the STAR charity in raising three quarters of a million pounds towards a new dedicated unit expected to be completed in 2016.
- The trust had met all its referral to treatment targets but had seen challenges in four specialties. The trust was aware of the challenges within these specialties. For example within dermatology there had been problems in appointing consultants. This was recognised as a national problem; as a result the trust had been reviewing the care pathways with the commissioners. The waiting time targets were constantly reviewed and discussed at the monthly waiting list group meetings. We were told that the Trust had consistently exceeded their targets but was finding it increasing harder to meet them. As a result work was being undertaken on demand forecasting to increase the capacity of the outpatients and radiology departments.
- For the outpatients departments, the target was for patients not to be waiting longer than 18 weeks from the time their GP referred them to the hospital to when they started treatment (known as the referral to treatment time or RTT). Overall we saw that the outpatients department was meeting its targets.
- The radiology department aimed to report on x-rays for the emergency department and inpatients within 12 hours and for other patients by the end of the next working day. It achieved this for 85% of the time for inpatients and 90% for outpatients. These key performance indicators are reviewed in conjunction with the patient flow project management board.
- The urology team had established one stop clinics for patients with kidney stones. The clinics ran twice a month. Patients presenting with renal colic with their GP or at the emergency department could be referred to the clinic. At the initial outpatient appointment, any diagnostic tests were completed. This had led to a reduction in the waiting times for appointments and treatment.
- All referrals to outpatients come into the central booking office. These referrals could be made electronically or paper. The electronic referral system was instigated following requests from GPs and was initially only used for rapid referrals. Because of the success electronic referrals were used for all referrals, however, paper referrals were still accepted. Once the referral was received it was sent to the relevant consultant for grading (routine or urgent). The consultants had to grade the referrals within two working days and return them to the booking office. Appointments were then allocated and confirmation letters sent to the patient who in turn phoned to confirm the appointment. If the bookings team had not heard from the patient within a week, a further letter was sent asking the patient to make contact to accept the appointment. If the patient did not respond to these letters they are discharged.
- When follow-up appointments were needed, staff in outpatients generated an 'outcome' form. Urgent follow-up appointments were dealt with straight away. For routine follow-up appointments some patients were given a patient initiated follow up appointment, with the timescale agreed between the patient and the clinician. The patient was monitored and booked immediately if they initiated the follow-up appointment or discharged if they choose not to have the appointment within the agreed timescales.
- The outpatient booking system and the process of discharging someone back to their GP was flexible. As an example, one patient ignored the appointment letters because of issues they were dealing with at the time. As a result the patient was discharged back to their



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GP. When the patient made contact to explain the situation, they were reinstated and given their appointment. This showed that whilst a policy was in place to make effective use of outpatient appointments, it was flexible enough for staff to take individual patient's situations into account.

- Patients could email or use the automated telephone service to accept their appointment. They would also use the telephone to speak to a booking clerk to confirm an appointment or to obtain further information. Patients were able to cancel or request a change of appointment using the online tool on the hospital's web pages.
- Within the outpatients and radiology departments, patients could choose to book in at the normal reception areas or use the self-check in machines. Staff were on hand to explain how the check in machines worked for those patients who had not used them before. Reception was automatically notified when patients had used this check in facility. This gave patients the option to use different check in methods depending on their preferences.

## Meeting people's individual needs

- The outpatients and diagnostics were located in a number of different departments across the hospital. We found all the departments we visited were fit for purpose with enough seating for patients. The only exception to this was the Haematology waiting which we observed was extremely busy with patients standing in the waiting area and out into the corridor. We asked staff if this was normal for this clinic and were told it was, we were told it was a very busy clinic.
- We saw that some of the outpatient areas had been redesigned to make the experience better for patients. As an example, rheumatology outpatients had colour coded all their clinic rooms to make it easier for patients to find the right room for their appointment. Patients we spoke with in the waiting area told us they preferred the colour system and found it worked well for them.
- Seating was available in all the waiting areas. Water machines were available for patients and staff use in the departments we looked at. For some of the clinics such as haematology offered patients the chance to go and get a drink or food in the hospital restaurant and be called via their phone when their appointment was due.
- The rheumatology outpatient department provided a phone line where patients could call and leave a message with any queries. When the service was

audited, it showed that patients did not find this service very useful. When patients had queries on their care and treatment, they wanted to speak to a nurse rather than leave a message. As a result, a pilot manned nurse helpline was established for two hours each day. The new service was again audited and this showed 100% of the 100 patients asked preferred the new service.

Patients (97%) said their query was dealt with and the service was helpful. Patients we spoke with in rheumatology outpatients all complimented the service but wished it was open longer.

- Some rheumatology patients needed their medicines via infusions that could sometimes take all day to administer. Usually this would take place in a generic day unit setting. At Salisbury hospitals dedicated rheumatology rooms were available for patients who needed infusions. Patients who used this service told us they preferred it because the staff were much more aware of their individual needs.
- To make x-ray services more accessible to patients, a GP walk in service was established which proved popular with both GPs and patients. Patients were very positive with the accessibility and promptness of diagnosis. This service was initially introduced in the satellite unit at Westminster Memorial hospital, Shaftesbury, followed by the main hospital and another satellite service in Westbury.
- When patients arrived whose first language was not English, interpreters were provided. The booking team had access to face to face interpreters and were able to book an appropriate interpreter for the patients appointment. If information leaflets were needed in other languages, this was arranged as necessary. The eye outpatients department automatically sent out their clinic letters in large print to make them easier to read for their patients.
- Appointment reminders were sent out via text where the patients consent had been obtained.
- Within the outpatients department, there was a dementia champion and link worker who acted as a trainer for other staff as well as a point of contact for further advice and support.
- Staff told us that when patients attended the department living with dementia, they would fast track them through the department to make sure they did not

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become distressed. Staff would also fast track other patients such as children, those with learning difficulties or anyone with increased anxiety because of being at the hospital.

- The signage overall in the hospital was good although we did speak to a few patients who were confused when finding their way to the radiology department.
- A range of patient information leaflets were available for the various clinics and procedures undertaken in radiology. These leaflets were sent out with appointment letters but were also available in the departments themselves. The leaflets were available in other formats as necessary such as other languages, audio and large print.
- Information boards were in place across each outpatient department. These gave any waiting times for the clinics and reasons for delays. Staff updated the boards throughout the day to keep patients informed of what was happening. Staff reinforced these with verbal explanations when necessary. The patients we spoke with confirmed that kept them informed of any clinic delays.
- A range of information was sent out with appointment letters including consent forms, maps of the hospital, contact details and any specific do's and don'ts that the patient should be aware of.
- We saw that a member of staff had been specifically funded by the Royal National Institute for the Blind and trained to run her own clinic. They were able to assess people's eyesight and if any visual impairments were found they initiated and coordinated any services that patient might require. This meant patients were able to be diagnosed quickly and receive any treatment or services they might need.
- At the time of our inspection the machine used for mammograms had been out of action for some considerable time following a flood in the department. Other provisions had been made for patients to attend the hospital in Southampton for their scans. However staff were concerned at the length of time it was taking to replace the equipment. The issue was documented on the department's risk register.

## Learning from complaints and concerns

- The patients we spoke with told us that they felt able to talk to staff if they had any concerns. Patient said they had confidence that staff would resolve their concerns if they could. When themes or trends were noted in

complaints or concerns, the customer care team would work with the departmental managers to look at the themes and identify any work that could be undertaken to improve the patient experience.

- We saw examples of where the departments had learned from complaints and put measures in place to prevent similar complaints. For example, one complaint had highlighted a particular patient call bell in a toilet did not work. Following the complaint a system was put in place to check all patient call bells in the radiology department on a regular basis to make sure they were all working appropriately. In another example, maps were changed that directed patients to the mobile scanner following complaints from patients who found the previous maps confusing.
- In another complaint, patients complained about waiting in fracture clinic without having their X-rays first. This resulted in increased waiting times for patients. As a result staff now speak to each patient as they arrive to acknowledge their arrival and to check they had been for their X-ray. Information was also included in the appointment letters and the self check in kiosks.
- Complaints and concerns were discussed at the multi-disciplinary team meetings held monthly. The themes were discussed together with any actions that needed to be taken as a result. We saw evidence of these discussions in the MDT meeting minutes for October and November 2015.

## Are outpatient and diagnostic imaging services well-led?

Good



We rated the leadership in the outpatient and diagnostic imaging department as good.

Both departments were led by senior clinical staff with support from the directorate management team. Staff told us they felt very well supported by their immediate line managers, the divisional management team and the trust executive team. Staff knew the vision for the trust and constantly strived to make sure every patient's experience was outstanding.

Governance systems were in place. Staff understood the risks within the departments and where improvements needed to be made. Action plans were in place where

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necessary with appropriate timescales. The diagnostic imaging department was working towards achieving accreditation with the Imaging Service Accreditation Scheme.

We saw that in the friends and family test, 96% of patients said they would be very likely or likely to recommend the departments to others. However, this rose to 100% in some of the outpatient clinic areas such as urology, rheumatology, plastics and oral surgery.

## Vision and strategy for this service

- The overall vision for the trust was to provide an outstanding experience for every patient, through patient centred and safe care, professional and friendly staff/service and a service that is responsive to people's needs. Staff we spoke with were all aware of the overall trust vision and strategy. Staff were aware of the role they played in helping the trust to achieve its vision and felt proud that they worked the trust values into their daily work.
- The wide strategy for the outpatients department was for all outpatient areas to be under a single management and single booking service. The start of this strategy was to implement the outpatient management and nursing structure. Once this had been achieved, action plans would be developed with staff to achieve the strategy. The purpose was to make sure all outpatient areas were providing a consistent quality service to all patients. The single booking service would mean that all appointments for patients would come from one department. This would reduce the chances of a patient getting numerous letters for different appointments on different days.

## Governance, risk management and quality measurement

- We saw that within the outpatients and radiology departments, everyone was encouraged to be involved in governance. Staff told us that it was all of their responsibility and not just managers. Issues would be raised and discussed at a local level at team or multi-disciplinary team meetings. The minutes of these meetings would feed up to directorate meetings and the divisional managers and then to the 'three on three' meetings which contained senior managers and executives. Information was also cascaded down through this governance structure.
- At the time of our inspection the radiology department was working towards achieving Imaging Service Accreditation Scheme (ISAS) accreditation. ISAS is a patient-focused assessment and accreditation programme. It is designed to help diagnostic imaging services make sure that their patients consistently receive high quality service, delivered by competent staff working in safe environments. As the only national accreditation scheme for diagnostic imaging, it showed that the department wanted to make sure the services it provided to patients were the best that they could be.
- Peer review meetings were held within radiology because staff recognised the need for shared learning from complaints and incidents. Cases were presented and discussed at the meetings which was open to all radiologists and radiographers. The objective was to identify the cases that had an effect on the patient's outcomes and where possible put measures in place to improve the patient experience.
- Radiologists participated in an online resource from the Royal College of Radiologists. The 'educational rescue to improve safety' allows consultants to submit totally anonymised cases which all members of the college have access to. This allowed shared learning through a large number of consultant colleagues across the country.
- Risk registers were in place. When the risks were identified, they were colour coded depending on the risk score. These ranged from blue, minimal risk to red, high risk. The risk score were reviewed following any initial action that had been taken. All the risks had timescales and actions against them. The majority of the risks on the risk register were current, however we did see two long standing risks. Both risks had been acknowledged they were long standing but were reviewed regularly. As an example one of the risks related to the lack of availability of medical notes at appointments. As a trust the incidents of notes not being available were very low however, this risk had been present on the register since February 2003.
- Where risks were identified, we saw evidence that the appropriate actions were taken. As an example, gaps had been identified in the IR(ME)R procedures especially around theatres. Once this had been identified the risk assessment was updated and actions identified. We observed the department was resolving these risks at the time of our inspection.

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- Radiology had a clinical governance lead that organised a half day study day every two months for clinical staff. We were told a key focus was to make sure information was fed back to staff as much as possible in relation to incidents and complaints.
- We were told that a significant problem for both outpatients and radiology was the delays incurred by the patient transport system. Whilst this was outside of the department control, staff were encouraged to complete incident forms as necessary. These incidents were fed through and discussed at the transport project management group held monthly. Concerns were discussed directly with the provider responsible for patient transport so that improvements could be made. The outpatients manager told us that they had started to see improvements in the service. This did not appear on the risk register that we were provided with by the Trust prior to our inspection but was added to the risk register in October when initial attempts to resolve the transport issues with the provider had failed.
- The friends and family test data for outpatients were very positive. The departments overall got a low response rate (8.3%) in patients completing the questionnaires. But for those that did, in September 2015, for outpatients overall, 96% of patients were either likely or very likely to recommend the department to others. A lot of the individual outpatient clinic areas scored 100% such as Urology, Oral surgery, Rheumatology and plastic surgery. The general medical and surgical outpatient area was the only department that scored less than 90% (88%).
- Comment boxes were in place across all the outpatient and radiology departments. Comments were reviewed and the themes displayed in the waiting areas together with a 'you said, we did' board. This showed that the patients views were listened to and acted upon where appropriate. Explanations and reasons were given where changes could not be made.

## Leadership of service

- The majority of the staff we talked with in the departments spoke highly of their colleagues, immediate managers, directorate and trust managers. In outpatients, staff particularly felt their new manager was very supportive and valued them as individuals.
- Staff told us that the chief executive was approachable and knew what was going on in their departments.

## Culture within the service

- The culture within the departments was focused on the needs of their patients. The culture was open and honest. One member of staff summed up the culture when they told us "we do what the patients want and need, not what we as staff want."
- Staff told us they felt valued and respected by their colleagues and managers.
- Some staff were negative about the culture within radiology, with it being described as a 'them and us' culture. We were told that imaging directorate management did not understand the specialty. We spoke with a number of staff within radiology and the majority of staff did not share this same feeling on the culture.

## Public engagement

## Staff engagement

- We saw evidence that the feedback given by patients was fed back to staff within each department as well as trust wide. As an example of this, we saw emails from the trust informatics team to the rheumatology outpatients department. This detailed the feedback the department had received the previous week. Staff were able to see if patients would recommend the department to others and any comments that the patients had made. The majority of these comments were overwhelmingly positive.
- The bookings team regularly involved the relevant consultants in the state of their waiting lists. The booking staff felt this was important in gaining their co-operation in bringing the waiting lists down.
- Staff we spoke with felt actively engaged in changes that affected their departments. They told us they had opportunities to give their views and felt listened to by their managers.
- Regular staff meetings were held across both imaging and outpatients departments. The minutes of these meetings showed a range of issues were able to be discussed. Feedback was given from previous meetings and from patient feedback.

## Innovation, improvement and sustainability

- The urology team had established one stop clinics for patients with kidney stones. The clinics ran twice a month. Patients presenting with renal colic with their GP

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or at the emergency department could be referred to the clinic. At the initial outpatient appointment, any diagnostic tests were completed. This had led to a reduction in the waiting times for appointments and treatment.

- To make x-ray services more accessible to patients, a GP walk in service was established which proved popular

with both GPs and patients. Patients were very positive with the accessibility and promptness of diagnosis. This service was initially introduced in the satellite unit at Westminster Memorial hospital, Shaftesbury, followed by the main hospital and another satellite service in Westbury.



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

## Information about the service

The Duke of Cornwall Spinal Treatment Centre specialises in the total management of patients paralysed following spinal cord injury or non-progressive spinal cord disease. This includes ongoing advice and support to meet the changing needs of the patient.

The centre provides this service for the whole of the South and South West of England and serves a population of 11 million people. The Centre is situated at the Salisbury District Hospital site. There are two wards in the Spinal Treatment Centre, Avon and Tamar wards, each with 21 beds (although four were closed on Avon ward at the time of inspection).

The service also provides an acute outreach service for patients living with a spinal cord injury or disease. Diagnostic imaging is carried out by the Clinical Radiology Department. However, staff from the Spinal Treatment Centre provide staffing.

During our inspection a team of inspectors, a pharmacy inspector, specialist advisors, and an expert by experience observed practice and spoke with 32 staff, four volunteers, 20 patients and two carers and looked in 15 medical records and ten care plans. We received one comment card relating to the spinal treatment centre.

## Summary of findings

Overall we rated the Duke of Cornwall Spinal Treatment Centre to require improvement.

There was inadequate management of a video uro-dynamics and outpatient appointment backlog with poor understanding from the trust as to the number of patients waiting on the lists or identification of the risks posed to this group of patients.

There was a dichotomy between the experiences of inpatients in the Spinal Treatment Centre. Some patients were having positive experiences and were part of a community which included the staff. However, some patients who were not part of this group felt isolated, ignored and lonely. Some said they felt the days were very long and they had nothing to do. Access to therapies was limited due to staffing shortfalls for both physiotherapy and occupational therapy and this was having an impact on patients rehabilitation.

Some patients told up of positive experiences of care and said that they were treated like friends to the staff although this was not universal. We saw good examples of where group work was conducted to prepare inpatients for living with their injury after discharge. The inclusion of charity workers in the group gave patients information and knowledge based on experience. There was a robust MDT process in place to ensure that all

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patients and their carers were included in their care. Goal planning meetings were used to track progress and there was good relationships with organisations outside of the hospital.

A requirements notice was issued around the accurate recording of resuscitation equipment records to ensure that equipment used was safe to do so. Records were missing multiple times in the months prior to the inspection showing that this equipment was not checked for safe use.

## Are spinal injuries centre services safe?

Requires improvement



We found spinal services to require improvement for safety.

Staffing levels on a daily basis were inconsistent and relief heavily on bank, agency and additional nursing assistant staff to fill gaps, although they were inducted. Ventilated patients who required one to one care were not receiving this increasing the risk of issues or complications going unnoticed. However, when raised by CQC inspectors this was quickly rectified. Doctors were stretched and sometimes struggled to maintain their day to day responsibilities. Resuscitation trolleys and resuscitation crash bags were regularly not checked in line with trust policy. Some areas in the spinal treatment centre were unclean and dusty. Some staff were not following the trusts infection control policy. The use of medicines were well documented in patient charts. Incident reporting systems and processes were robust and staff were encouraged to report on a computerised incident management system. Duty of Candour was understood by all staff we spoke with.

### Incidents

- Openness and transparency was encouraged around safety, and incidents had appropriate through investigations with learning shared widely.
- Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses. The spinal treatment centre reported a total of 23 incidents between the months of October 2014 and November 2015. All incidents were reported on and investigated using a computerised incident management system. Three of these were classified as serious incidents requiring investigation (incidents where patients, staff, visitors, or members of the public experience serious or permanent harm) which were all investigated appropriately. All three had detailed investigation reports dictated by terms of reference and a list of recommendations and actions.
- Staff we spoke with were aware of all three serious incidents and could describe the learning from them. For example, one serious incident was concerning a grade four pressure ulcer acquired within the service.

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This individual received care at the spinal treatment centre. However was considered non-compliant with the use of pressure relieving equipment resulting in the pressure ulcer. Learning was taken from this investigation and shared with the whole centre. When questioned staff could identify the causes of the incident and describe how practice has changed as a result.

- Nurses described the procedure for reporting incidents which involved letting the nurse in charge know, as well as the doctor, in addition to reporting through the computer management system. Incidents were investigated by the ward sister, who provided individual feedback and areas for improvement. In addition to this learning improvements resulting from incidents were shared at weekly team meetings, and via email. However, some nurses we spoke with said that there was disparity between the level of detail of feedback received on both Avon and Tamar wards.
- The Duty of Candour is a regulation in the Health and Social Care Act 2008 Regulations 2014 which describes what providers must do to make sure they are open and honest with patients and their families when something goes wrong with their care and treatment. All staff we spoke with were clear in both their understanding and practical application of the Duty of Candour. The safety thermometer is a national prevalence audit which allows the establishment of a baseline against which improvement can be monitored. There are four key measures as part of the safety thermometer which included falls, pressure ulcers, venous thromboembolism and urinary tract infections in patients with catheters. Managers stated that they did not have oversight of the safety thermometer results as this was managed by the central governance team in the trust and could not tell me how the centre was performing and did not regularly receive copies of this.
- It is best practice for the safety thermometer to be displayed in ward areas to indicate to patients and members of the public on their performance. This was not displayed however the spinal treatment centre's key performance indicators were. This information was in small print and elevated to a high position on a notice board meaning it would be difficult for patients in a wheelchair or with visual impairment to read.

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## Cleanliness, infection control and hygiene

- We observed on Tamar ward that some equipment did not look physically clean. We also observed that toilets on the ward were not clean and had rust on the fixings. In the pool area we saw suction equipment which was visibly dirty and dusty. This was raised with a senior member of staff who said it was never used or would be used as no one is trained in its use.
- We saw on several occasions that staff were walking around the ward in gloves and aprons without changing them between patients.
- Infection control audits for the four months prior to the inspection were generally good but could be improved in some months. Data provided to us showed that in April 2015 no doctors which were observed passed the hand hygiene audit and that in June 2015 no data was provided for either Avon or Tamar wards. The spinal treatment centre outpatient department performed poorly on the hand hygiene audit for the last four months with some data missing and the average compliance for June 2015 being 26%. However, 100% compliance was obtained in July 2015. The impact of this was not seen in performance results of hospital acquired infections as there were none in the six months prior to the inspection.

## Environment and equipment

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- Between both Avon and Tamar wards there was one resuscitation trolley. Hospital policy states that this should be checked daily to ensure reliability and to allow for the replacement of essential equipment. This daily check was missed nine times in October 2015 and 11 times in November 2015. This was raised with managers during the inspection and an email was sent to all staff reiterating the importance of these checks.
- There were incomplete records for the weekly checking of cardio-crash bags. The forms used did not allow for dates to be included therefore staff could not reassure inspectors as to when the last weekly check was completed.
- There were call bells in bed bays which were digital. This meant that patients could take their call bells anywhere in the unit without losing signal. Patients had access to a large dining room where there were tables, chairs and televisions. Staff had limited visibility of patients in this area.

## Medicines

- Nursing staff we spoke with reported a good medicines supply from the pharmacy department with daily deliveries, even at weekends. We were informed that pharmacy staff undertook weekly stock checking, top up, and date checking. Nursing staff undertook checks for additional items such as fluids and patient specific items. A clinical pharmacy service was available for one hour each weekday to manage concerns.
- In relation to medicines, we were given examples of where incidents had occurred, for example, omitted doses and changes in controlled drug storage. These were reported appropriately and staff had a good understanding of trends in these incidents.
- The treatment room was locked with access restricted by swipe card; we were told that all Band 3 staff and above have access to this room. However, medicines within this room were stored within locked cupboards, and we were told that only Band 5 nurses and above had keys to open these cupboards. We saw the separation of storage of topical, oral and injectable medicines, as well as segregation of patients own medicines.
- Within the treatment room were two locked medicines trolleys. However, these were unorganised and contained medicines for six patients which should have been in the patient's own cabinets at their bedside. This included medicines for one patient who was no longer on the ward. We additionally saw three bottles of liquid medicines that were in use but had no date of opening on them, and three further medicines that were stored on an open shelf, under the trolley, instead of being locked away. Stock medicines, such as antibiotics, were held in the treatment room and we spot checked three items and found them to be appropriate and within date.
- Nurses described that patients' own medicines were stored in locked cabinets by their bedsides; these had been in place for four months. We were told this system worked well and reduced stock holding. During the time of the inspection two patients on the ward were currently self-medicating.
- Medicines requiring refrigeration were kept in a locked fridge. There was regular recording of fridge temperatures which were within range. However, only single, current readings were recorded without maximum or minimum temperatures which are considered best practice. We spot checked three items stored in the fridge, and found them to be appropriate and within date. However, we also saw medicines for a patient no longer on the ward kept in the fridge.
- We observed storage of controlled drugs (CD) within the metal CD cupboard, which was locked with restricted access. Nurses told us the CD cupboard was stock checked once weekly by two nurses. We spot checked three items in the cupboard and found them to be appropriate and within date, with suitable recording and quantities. We also saw the storage of emergency medicines; we spot checked three items and found them to be appropriate and within date. We were told that these items were checked by pharmacy staff, but staff were unable to show us a list of contents that should be included. There was an accessible hypoglycaemia treatment box with suitable contents.
- In the corridor, there was a resuscitation trolley with a crash bag which was sealed. This included an appropriate oxygen cylinder, with additional cylinders kept in a decommissioned shower room which has been allocated as a storage room.
- Although medicines risk assessments were present there were various inconsistencies in the recording of medicine management in all five of the records we checked. In three of the five records we found that weight was inconsistently recorded. We also found that indication of doses for treatments were infrequent in all case notes we reviewed.

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## Records

- Patients either admitted as an inpatient or as an outpatient to The Spinal Treatment Centre had their own set of spinal notes separate from the main hospital notes. These were kept for life by the service. We found that all records were stored securely in locked cabinets which could only be accessed by relevant staff. There was an office where all records were stored which was locked securely.
- Records audits were completed on a monthly basis. Both Tamar and Avon wards performed well in these audits highlighting good compliance with record completeness.
- We looked in fifteen care plans and sets of notes. A majority of these were completed, legible and in chronological order. However, we found that some forms within them were not always completed in a timely way. Three of the ten records we looked in had communication records not completed by nurses or therapy staff. We found that some records were not easily legible and the wording used within them unclear. Phrases such as “by the looks of it” were used making their purpose unclear.

## Safeguarding

- Systems, processes and practices were in place to protect people from avoidable harm and these were communicated to staff.
- Mandatory training in safeguarding adults and children were both above the trust target of 85% (adults safeguarding training at 97% and children’s safeguarding training at 96%). When questioned about it staff had a good understanding of safeguarding and their responsibilities within it.
- Staff in the outpatients department had received extra training in the management of patients dealing with emotional distress after discharge and were trained in picking up the signs and signals from the patient which may raise safeguarding concerns. The team had direct links with the trust safeguarding team and local authorities.

## Mandatory training

- Compliance with the trusts target of 85% was variable for mandatory training levels. The lowest levels of training were around hand hygiene with 69% compliance. For some areas there was missing data. For

example, in terms of mental capacity act training and resuscitation training there was data missing for either Tamar or Avon wards bringing the averages of compliance down. Resuscitation training levels were at 76%. Information governance training was at 94% compliance, infection control training was at 92% compliance, moving and handling was at 87% compliance, fire training was at 88% compliance.

- Student nurses were given a welcome pack when attending the spinal treatment centre with a list of mandatory training competencies which needed to be discussed with qualified staff and achieved.

## Assessing and responding to patient risk

- We found that risk assessments were completed appropriately and when asked staff were able to demonstrate understanding and knowledge around them. Record audits demonstrated that compliance was good with the number of observations recorded, the timeliness of these observations and appropriate actions completed as a result of these observations. This showed that staff responded well to the changing risks of patients.
- Staff we spoke with were clear of the process involved when managing a deteriorating patient although it rarely happened in the Spinal Treatment Unit. Staff were aware of who to contact when this did occur and received training in basic life support.
- Call bells and nursing responsibilities were divided between nurses and nursing assistants in relation to geographical areas in the ward, meaning that they look after clusters of patients. However, nurses were also responsible for ‘long stay’ patients in different parts of the ward meaning that when a call bell was used they could be away from their main patient group for some time. Two weeks prior to the inspection Avon and Tamar wards worked on different call bell response systems. Tamar ward had adopted Avon wards system to gain continuity between wards, improve call bell response times and improve staff visibility to patients. Nurses commented that the system was difficult to get used to and complicated. We were told that although full time staff had training in the use of the new system bank and agency staff had not. The change had been discussed at Ward Team Meetings and all bank & agency staff are informed about it in their recorded ‘ward orientation’.
- All patients had call bells and there were emergency call bells in every bay. Patients who were unable to use their



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arms had head operated call bells to get the attention of staff. We observed one of the ventilated patient's call bells went off. However, the staff nurse did not respond. When questioned as to the reason we were told "its ok, the physiotherapist will be in there giving treatment". She could not confirm that this was happening and the patient may not have been seen as quickly by a nurse as they could have been.

- Pressure care was managed well in the spinal treatment centre. Avon ward had two grade two pressure ulcers (some of the outer surface of the skin (the epidermis) or the deeper layer of skin (the dermis) is damaged, leading to skin loss) attributable to the service in the six months prior to the inspection.
- Tamar ward had three grade two pressure ulcers and one grade four pressure ulcer (The skin is severely damaged and the surrounding tissue begins to die (tissue necrosis) with the underlying muscles or bone having the potential to be damaged) in the last six months.
- The spinal treatment centre had access to equipment to reduce the occurrence of pressure ulcers. Pressure mapping equipment and software were used to identify with accuracy the exact pressure points on a patient's skin and provide intervention to relieve these areas. For patients who spent long times in bed an automatic turning board could be used to ensure appropriate turning. Patients who would benefit from these were able to continue to use them after discharge in a community or social care setting.

## Nurse staffing

- As defined in the NHS standard contract for specialised rehabilitation it stated that the centre should have, based on 42 beds, 63 whole time equivalent nurses, a third of which should have specialist rehabilitation training. The trusts establishment was comparable to this. However, it was highlighted in the trusts most recent skill mix review that the number of registered nurses in post was below 50% of what it should be and commented that this was supported by a larger than establishment cohort of band three nursing assistants with specialist rehabilitation competencies and the use of bank and agency staff. For example in August 2015 on Tamar Ward out of a total of 93 shifts, 27 of them had staffing levels for registered nurses between 80% and

60% with three of them having staffing levels of registered nurses below 60%. When this occurred more band three staff were placed on shift or staff from other wards were seconded to the ward.

- At the time of the inspection there were four beds closed to maintain a suitable staffing level for the open beds. This reduced the risk of staff being stretched to deliver care to too many patients at once.
- During the inspection there were three patients who were ventilated. These patients were high risk due to their lack of physical ability to raise the alarm if something went wrong and was identified on the trust risk register that they required one to one nursing care at all times. We found that this was not happening and that patients were left unattended and that they were not in clear sight of the nurses station. We raised this with the trust who added an extra member of staff and a temporary nurses station (a computer on wheels) outside of the ventilated patient's room to ensure visibility. During an unannounced inspection we found that this was continuing and that patients remained to be safe.
- The spinal treatment centre offered an outreach service for potential inpatients to meet with a nurse prior to admission at their acute hospital. However, this service was not continued when staff were on leave due to lack of additional staff.

## Medical staffing

- As defined in the NHS standard contract for specialised rehabilitation it stated that the centre should have, based on 42 beds, 4.2 whole time equivalent spinal cord injury consultants and 5.25 whole time equivalent training grade doctors. During the time of the inspection the Trust employed one Associate Specialist and two Consultants, reducing the capacity and medical cover for the centre. The centre was out to advert for one more junior grade doctor and job plans were being produced for consultant roles.
- We were told by doctors that over the last few years the spinal treatment centre had seen a change in its demographic to older patients with more complicated co-morbidities such as diabetes, heart disease, renal failure and other chronic conditions which resulted in a greater workload for staff which they struggled to manage at times.
- Junior grade doctors provided general day to day medical cover for the whole unit. One of the doctors was

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a locum who has been working in the unit for the last four years and the other had only been in position for several weeks prior to the inspection. The longevity of the second junior doctor role was uncertain as their contract was due to end several weeks after the inspection. One junior doctor commented that the role of managing the spinal patients can be daunting and had a heavy workload.

- Consultants felt there was too much reliance on junior medical staff to perform duties such as taking bloods, rolling patients and moving beds. Although this was deemed essential for patient care having more nursing staff would allow the doctors to perform the roles they should be doing.
- Due to staffing shortages when junior staff took annual leave consultants would be required to 'act down' to cover routine care having an impact on their outpatient capacity and administration capacity.

## Allied Health Professional Staffing

- As defined in the NHS standard contract for specialised rehabilitation it stated that the centre should have, based on 42 beds, 11.5 whole time equivalent's physiotherapists 11.5 whole time equivalent occupational therapists. At the time of the inspection the centre had six whole time equivalent physiotherapists and 5.4 whole time equivalent occupational therapists. Although not unsafe, this was having an impact on the levels of physiotherapy and occupational therapy services available to patients, the timeliness of these appointments, and access to additional facilities.

## Major incident awareness and training

- The major incident plan was available in the spinal treatment centre. Senior staff were aware of its location and understood the centre's roles and responsibilities during a major incident. The impact a major incident would have on the spinal treatment centre would be minimal. However the nearest car park to the centre would be used as a media point.

## Are spinal injuries centre services effective?

Requires improvement



We found spinal services to require improvement for its effectiveness.

Evidence based fundamental standards were agreed nationally between all spinal treatment centres. However, compliance with these standards was inconsistent. Data collection around patient outcomes was limited and was not used to assess and improve the service. There were multiple training programmes and competency programmes for all grades of staff, including students, bank and agency nurses, but at the time of the inspection there was no oversight as to who was competent at which task. Staff were asked to perform a self-assessment of their competence rather than having it monitored and effectively evaluated. Since the inspection a skills and competency database has been introduced.

There were positive examples of multidisciplinary working both within the spinal treatment centre and with organisations outside of the hospital. We were given examples where challenges were managed well using a multidisciplinary team approach. Patient goals were an active part of the rehabilitation process in the spinal treatment centre with meetings including the patients and their relatives. Although limited, patients had access to access to a gym and swimming pool.

## Evidence-based care and treatment

- Patients did not consistently have their needs assessed and their care planned and delivered in line with evidence-based, guidance, standards and best practice. The spinal treatment centre had worked with other spinal services nationwide and the spinal cord injury clinical reference group to define the Fundamental Standards for Adults Requiring Spinal Cord Injury Care, the document which all centres use as baseline standards. The spinal treatment centre was compliant with many of the fundamental standards. However, it was not meeting criteria including: timely review of patients post discharge and the evaluation of patient outcomes.

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- The centres local and trust policies were easily accessible on the intranet. Staff we spoke with were confident about finding information quickly.

## Pain relief

- Pain was well managed in the unit and patients who requested analgesia received it quickly.
- Either upon referral from a member of staff or at the patients request a referral could be made to the pain management team within the hospital to manage more complex pain relief requirements. This included the assessment and management of pain for patients less able to communicate.

## Nutrition and hydration

- All patients had their nutrition needs and hydration needs met. They were well documented in all patient records and in care plans we looked in.
- Although dieticians were not stationed directly in the spinal treatment centre, referral to them was actioned quickly.

## Facilities and equipment

- The centre had a dedicated wheelchair workshop to ensure that every patient got a bespoke wheelchair made for them which could be changed and altered at any point during their recovery. This included battery powered wheelchairs as well as standard wheelchairs.
- The spinal treatment centre had access to software and hardware to allow patients to control a computer using eye movements. This allowed them to have use of laptops and to aid communication and access facilities which may otherwise have been unavailable to them.
- The centre had access to a hydro therapy spinal pool. The pool was approximately 15m long and the water temperature was warmer than that of a swimming pool which helps with rehabilitation. The centre also had access to a gym which was also available to patients for limited times.

## Patient outcomes

- Managers said that although personal outcomes were recorded (such as length of stay, ranges of movement, hand outcomes and muscle chartings) they did not have an oversight of how effective the centre is as a whole of providing care and patient outcomes.
- The spinal treatment centre contributed to national spinal databases for data collection and analysis

purposes but has not contributed to this for a long period of time nor could they tell inspectors information concerning the results of these databases and actions taken as a result.

- Outreach teams were able to attend geographically distant patients within five days of referral which was within national targets.
- A clinical audit programme was used within the spinal treatment centre to assess the effectiveness of the treatment they are giving which generally produced good results, for example. .... Some improvement was required with the discharge summary audit which led to learning and processes and protocols being changed. This was due to be re-audited shortly after the inspection.

## Competent staff

- There was limited oversight of staff competence with no robust system to ensure competence of all staff. We were told that in order to gain oversight the managers would be required to read through everyone's personal file to record competence. Staff were asked to fill in a self-assessment for competence in all tasks in the centre including specialist tasks such as spinal manual handling. After the inspection a matrix approach to competency had been developed to assist in gaining oversight."
- All new staff (between HCA and senior nurse level) were given a development and competency pack to complete with the aim of introducing them to specialist skills required for spinal treatment and to develop their own personal continual professional development. However, there was no indication in these packs that staff needed to read policies and standard operating procedures around the competencies they were getting.
- Agency staff attended a spinal cord programme when they were inducted and a register was kept of this competence. Locum medical staff were well supported during their induction period by both consultants and nursing staff. Appropriate training was offered which allowed them to perform their role effectively and safely.
- Student nurses were given a welcome pack when attending the spinal treatment centre with a list of competencies which needed to be discussed with qualified staff and achieved through practice.

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- Staff we spoke with said they were supported in revalidation and had their annual appraisals on time. They complimented the good quality of the appraisal system and said it had been improved since it changed earlier in the year.
- We were given conflicting information concerning the competencies of staff looking after ventilated patients. The critical care team were contacted for advice in an emergency situation concerning ventilated patient and all concerns went through respiratory physiotherapists. We saw a clear competency framework specifically for teaching all staff in the management of respiratory patients.
- Through charitable funding the trust employed two recreational co-ordinators. This team managed days out and activities for patients being treated at the spinal treatment centre. It was not clear what formal training these staff members had received to manage patients in these environments. We were told that sometimes a HCA attended these events and if anything happened 999 would need to be dialled. The recreational co-ordinators had both received appropriate assessment to drive a patients' minibus. We were informed of the types of manual handling performed but could not be told about training offered or given to allow them to do this safely.
- Outpatient staff delivered multiple study days to all levels of staff including local staff, community staff and agency staff in topics such as bowel care and delivering ongoing care in the community.

## Multidisciplinary working

- All necessary staff, including those in different teams and services, were involved in assessing, planning and delivering people's care and treatment. Each patient at the spinal treatment centre had a monthly meeting with their doctor, named nurse, physiotherapist, occupational therapist, and other key staff to discuss discharge and progress with their rehabilitation. The previous months goals were discussed and reflected upon and the next month's goals were set.
- Three patients we spoke with were positive about the goal setting process. One patient commented that these meetings were good and allowed them to understand where they were in the rehabilitation process. At the

Goal Planning Meeting a record sheet was completed by staff in conjunction with the patient, to reflect the discussion and outcomes of the meeting, and this was placed in the patient's records.

- All staff were actively involved in team working for the best interest of the patients. Communication was good between both clinical teams and non-clinical teams (such as housekeepers). It was clear from care plans and records that all teams within the unit worked collaboratively rather than as separate specialities.
- There was a programme of clinical multidisciplinary team (MDT) meetings ranging from spinal surgery, to radiology and urology. Patients were also discussed in relation to specific audits which highlighted concerns or issues. Each patient discussed had comments made either in their notes or dictated for letters with some MDT meetings having specific record sheets.
- Specific issues were discussed in MDT meetings including delayed discharge of patients, and managing the care of bariatric spinal patients with detailed discussion and knowledge sharing as to the challenges these bring.
- Staff said there were good working relationships with both GP's and social services although commented that the geographical and various ways of working from these services can be challenging. Links had been set up with the discharge co-ordinators to have named links in all services they cover to ensure smooth transition and transfer of information. Patients were also given the names and telephone numbers of social workers to allow them to call at any time.
- We were told of one example with a particularly challenging patient was requiring discharge so social services met with them for a whole day to attend therapy sessions, talk to staff, the patient and their carers and relatives.

## Rehabilitation, pathway and transition

- Patients were assessed for admission using nationally agreed criteria. The weekly referral meeting was attended by the patient, their family, Acute Outreach Nurse Specialists, the Outreach Admin Assistant, Spinal Respiratory Specialists and the Spinal Centre's Consultants. Additional information (previously requested) from GPs and staff from other specialties was discussed to enable the team to effectively assess the patient's suitability for inpatient admission.

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- The centre had access to dedicated discharge accommodation where patients who were nearing discharge were able to attempt living independently with the security of staff nearby. This flat contained two bedrooms, a bathroom, a lounge and a kitchen. One patient who was being discharged was due to spend a weekend in the flat with her husband to see how they coped.
- Prior to discharge the outpatient team met with the patients to introduce themselves and to discuss ongoing care after discharge and the process for attending as an outpatient. This ensured continuity in care after discharge.
- Quality dashboards indicated that the centre was generally below but near to national average for its length of stay targets. For two indicators the centre performed poorly (non-clinical delayed discharged for ventilated and non-ventilated patients). However, there were justified reasons for these breaches in targets. Doctors we spoke with commented that managing discharge can be difficult depending on the comorbidities of patients and the level of ongoing rehabilitation they need provided by the community teams post discharge. The trust tried to communicate well with community hospitals to support patients through a staged discharge home.

## Seven-day services

- Out of hours medical cover was provided by the on-call medical team at weekends. A spinal centre consultant was on call 24 hours a day who could be contacted via the trusts main switchboard. We saw evidence in patient notes of medical care being provided at weekends in a timely way after request. One example was with a physiotherapist who requested a medical examination of a patient which was completed within two hours on a weekend.
- Access to therapies during the weekend was limited. One patient commented that there was limited access to therapy staff at the weekend and that they did not always have their therapies appointments due to staffing shortages.

## Access to information

- The information needed to deliver effective care and treatment available to relevant staff in a timely and

accessible way. Test results and diagnostic imaging results were available when required and there were minimal delays in receiving these. There were processes in place to receive urgent results if required.

- Patients had appropriate checklists and forms filled in prior to discharge. These were completed by the discharge co-ordinator. These forms were different for discharge home or discharge to a community hospital or adult social care setting.

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

- Consent, mental capacity act and deprivation of liberty safeguards was considered for every patient and where there were concerns these were generally acted upon. However, we saw one example in patient notes where capacity was questioned with no capacity assessment to follow this up. We saw that any do not attempt resuscitation forms in place were discussed and updated at handover.

## Are spinal injuries centre services caring?

Good



The care in the spinal treatment service was rated as good.

Staff provided compassionate care and respected patient's privacy and dignity. There was a dichotomy between patient experiences in the spinal treatment centre. Some Patients spoke about staff as if they were friends rather than nurses. A patient got married in the centre and had the full assistance and support from staff that went above and beyond the call of duty to ensure their day was special. Through structured sessions inpatients and their carers and relatives were fully supported and involved in their care both in the spinal treatment centre and on discharge. Sessions called 'live it' enabled patients to discuss concerns and gain invaluable information for living with a spinal cord injury.

## Compassionate care

- Patients were treated with kindness, dignity, respect and compassion while they received care and treatment. We saw multiple examples of compassion being delivered by staff to both patients and their carers and relatives.



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Patient's privacy and dignity were respected with curtains and doors shut appropriately. When they were closed staff asked permission of the patient before they entered.

- One patient we spoke with described the staff as if they were friends rather than nurses and gave us examples where they had sat with the patient and had long conversations with them about something other than treatment. Another patient commented when talking about the staff that "nothing was too much trouble" when caring for them.
- A patient got married in the spinal centre in the weeks prior to the inspection. The staff went with the patient's partner to get food from a local supermarket and used the discharge accommodation kitchen to prepare it. One staff member, who owned a classic car, collected the bride on the wedding day from their house and took them to the centre. After the wedding the patient and his wife were allowed to use the discharge accommodation that evening.
- Two patients commented on the caring and supportive nature of the staff at the spinal treatment centre. One patient said they were kind, considerate, and gave patients their full attention when listening.
- Friends and family tests were available for all patients to take and completion was encouraged by staff in the centre. Results were very good with 100% of patients who responded recommending the service in the last six months. However, it was unknown how many people responded to the survey as data provided was incomplete.

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

- An educational programme for patients called 'live it' had been set up for inpatients to manage the psychological wellbeing of patients after discharge. These sessions included looking after skin, bladder and bowel conditions as core topics as well as a range of additional topics including discussing sex, understanding pain and eating well.
- We observed a 'solve it' educational session where ten patients and one relative attended to discuss how to deal with everyday situations outside the hospital. In this session were two staff from the centre and a volunteer from a charity who was an ex-patient of the spinal centre. This session was focused on managing relationships and confidence after discharge. Patients

were discussing their anxieties and concerns as a group and were having these addressed. Further support was also offered to the patients after this if they wished to have it. The centre also developed a range of 'discuss it' sessions to enable patients to discuss things which were going well or not so well in their rehabilitation programme.

- Six inpatients we spoke with commented positively about the verbal information received from staff, in particular the acute outreach team who encouraged patients to ask questions on their care in the centre and forward after discharge.
- All doctors in the spinal treatment centre have an open door system which patients are informed about. This allows patients and relatives to come and talk with them at any time.
- Outpatient appointments were 40 minutes long allowing ample time for patient and their carers and relatives to discuss any concerns or worries. In these appointments were various staff members to allow for different inputs from different professional groups.

## **Emotional support**

- We observed on multiple occasions staff giving good emotional support to patients who were evidently in distress. During these occasions the patients had the complete attention of the nurse who remained with the patient as long as necessary. Although this positive experience was not universal. One patient and relative we spoke with raised concerns that communication between the patient and staff was limited and felt that staff were avoiding talking to them. They felt that staff come to see them daily without an introduction or explaining why they are there. Another patient felt that they felt isolated from other patients.
- Patients who had infrequent visitors had regular visits from the hospital volunteers. This was arranged by the volunteer co-ordinator. One example was with one volunteer who built a strong relationship with the patient and supported and encouraged them during their time at the centre. Three patients we spoke with appreciated the work done by the volunteer's to ensure that the patients had someone to talk too and engage with.

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- Three patients we spoke with found the chaplaincy service helpful. One patient said that they can be called anytime when required and another said that although they were not religious just talking to them sometimes helped with their mental wellbeing.

## Are spinal injuries centre services responsive?

Inadequate



We found the spinal service to be inadequate for its responsiveness.

People were frequently and consistently unable to access services including video uro-dynamics (VUD) and outpatients in a timely way for diagnosis, follow up and treatment and experienced unacceptable waits for these services. There were 467 patients waiting for VUD and 1024 patients in a waiting list for an outpatient appointment with no clear understanding from the trust as to how the risks to these patients were assessed.

Patients who contacted the centre get their scans and appointments first regardless of risk. There was no clear strategy to reduce these backlogs. Services were not planned or delivered to fully meet patient's needs.

There was a disparity between the experiences of some patients. While some patients were making use of gardens and away days to, for example football matches; there was a cohort of patients who felt lonely. One patient described that the days felt very long as there was nothing to do.

Patients and carers had access to a wide range of information and materials both through various charities and the treatment centre. When complaints were received they were managed well. However, we saw that there was local resolution of complaints and concerns with no oversight from managers as to the themes of these.

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

- In addition to re-admissions from the existing outpatient cohort requiring medical or surgical treatment, patients were admitted to the Spinal Injury Treatment Centre from acute providers, with the

majority of these coming from the three major trauma centres in their catchment area (North Bristol NHS Trust, University Hospital Southampton, and Derriford Hospital). Between August 2014 and September 2015 there were a total of 127 referrals.

- We found that during outpatient appointments there was reliance for GP's to arrange follow up examinations and investigations for ongoing care and support. The levels of support differed between different geographical areas. However, it meant that patients could have these appointments close to where they lived.
- We observed one outpatient appointments where the patient had had a long journey where there was a consultation but no other interventions such as diagnostic imaging or blood tests. The patient was not offered the choice of being offered a telephone or webcam consultation for future reviews.
- When we asked a manager about dementia awareness and management of patients living with dementia we were informed that they do not accept this patient group as they cannot be rehabilitated effectively.

### Access and flow

- People were frequently and consistently not able to access services in a timely way for an initial assessment, diagnosis or treatment and people experience unacceptable waits for video uro-dynamics and outpatient appointments.
- There was a significant backlog in the number of patients awaiting a diagnostic procedure called video uro-dynamics (VUD) although the trust did not know the scale of this backlog or who was at risk by not having it. This procedure showed, through the use of X-rays, what happens in a patient's urinary tract when it is filling and emptying. If a patient with a spinal cord injury had significantly reduced function to their bladder or bowel there is an increased risk of permanent damage and eventually raised blood pressure which could lead to a stroke. Data provided by the trust showed that during November 2015 there was a total of 467 patients on a list who required a scan.
- Best practice stated that a VUD should be done within 12 weeks of injury with follow up scans every three years. The longest waiting patient dated back to March 2012.

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- Managers in the spinal service told us that there were no actions in place to identify which patients were at greater risk of harm as a result of not having the scan and required it more urgently or how long patients had been waiting for their scan. This meant that those patients who required the scan most were not being seen first. One member of staff told an inspector that it's the patient's "who shout the loudest get seen first, rather than the ones who need it".
- As a result of the delay in patients receiving video uro-dynamics a patient who was due to be discussed in an multidisciplinary team meeting had to be delayed by one week as the scan had not been done delaying their treatment and management of their spinal injury.
- During the inspection capacity allowed for 20 appointments a month (provided there were no cancellations) with an average of 18 referrals per month. Action was being proposed to increase the capacity from two clinics (seeing five patients per week) to four clinics (seeing 10 patients per week).
- The centres capacity did not allow for swift clearance of the backlog with only 51 patients being cleared each year (which would take 6.5 years to clear the backlog). Costing and forecasting exercises have been completed to establish the commitment needed to clear the backlog. The most productive of these clearing the backlog in only 8.8 months which includes extending services in the evenings and weekends however this was performed in February 2015 with little progress since.
- One consultant commented that they were under pressure from managers to increase clinic capacity which would not be appropriate for the current medical staffing levels due to the reduction in inpatient workload. This concern was raised with senior management although no clear action plan was produced or shared with staff.
- Similarly there was a significant backlog in the number of patients awaiting outpatient appointments although the trust did not know the scale of this backlog or who was at risk by not having it. Data provided by the trust showed that during November 2015 there was a total of 1024 patients on a waiting list who required an outpatient appointment. However, we were told by management that there were patients who were requiring appointments on the list multiple times as

well as patients who may not need a follow up appointment and the actual scale was unknown. This increased the risk to patients who may have symptoms but were not being seen.

- It was a recognised national spinal standard that all patients discharged or referred for review by a spinal cord injury centre should receive appropriate life time follow up and within no more than three year intervals. The risk register stated that there had been patients waiting since 2010 for a follow up appointment. However managers challenged that the data was incorrect and told us that until a scoping exercise has been completed the length of waits would be unknown.
- Work had been done to minimise the number of patients who cancelled their appointments by calling them prior to their appointment. The number of patients who did not attend their appointment was at 7% in November 2015.

## Meeting people's individual needs

- Staff vacancies were having a negative impact on the responsiveness of the service to meet patients' individual needs. One patient we spoke with commented that the nurses struggle to get patients ready for rehabilitation in the mornings. We observed one patient who returned from the pool and was still wet. It took ten minutes before a member of staff was available to assist them in drying and changing.
- Reduced staffing numbers for physiotherapist and occupational therapists were also having an impact by significantly reducing the time available for each patient to have access to physiotherapy and occupational therapy increasing their rehabilitation time. When speaking to managers we were told that although they do not record or monitor the impact of this reduction, patients were being discharged prior to having optimum amount of rehabilitation and were coming back to outpatient appointments sooner.
- The average length of stay for patients in 2014 was 116 days meaning that patients became very knowledgeable about staffing levels and their competencies. Six patients commented that there was a difference in the ability between agency nurses and full time nurses in the centre. One patient commented that they felt more comfortable and confident in the nurses they knew well and that agency nurses did not know what they could do on their own without assistance. A patient commented that there were a few staff which

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understood them however some of the newer staff did not which affected the patients confidence. The patient said that “they can set you backwards” and that “you have to explain everything to them”. Three patients said that they had to tell agency staff which medicine they needed to take to prevent them from making mistakes. There were no incident reports to reflect near misses with medicine errors.

- We spoke with two patients who had negative experiences when being admitted to the spinal centre. One patient felt that they had taken a ‘step back’ when being admitted to the spinal treatment centre as they had been making progress with their rehabilitation while in an acute hospital and had been walking and building their mobility. However, upon arrival to the centre was placed on four weeks of recumbent rehabilitation bed rest setting them back. They felt that all they had gained in the acute hospital was lost and was “back to square one”. Another patient who was admitted spent one week on recumbent rehabilitation bed rest was not given any explanation as to why as they had been sitting up and mobilising in their previous hospital. Although this is considered best practice the lack of communication left patients not understanding the reasons why this was required.
- Patients had access to psychological services although sometimes this was limited. Patients were able to have either male or female psychologists who were available during the day. This service was available for carers and relatives also. However, one patient we spoke with was concerned about access to psychological services and the processes behind this. They said they filled in a form to get this service and was asked to fill in another form three weeks later by a nurse. The patient told us that they had not heard anything and had “given up on it”. The psychology team had recognised that sometimes referrals got lost and have tried to reduce this happening but couldn’t provide inspectors with detail as to how this was being achieved.
- We spoke with three patients who felt that access to facilities and therapy time was limited. Two patients we spoke with said they would have liked to get into the pool or the gym more and felt they should be available to patients. However, this was limited due to staffing restrictions.
- We spoke with four patients who felt that there were often no activities on for them although took part in the ones that were available. A patient commented that the days were very long when there was nothing to do. One patient we spoke with who was in a side room felt lonely as they do not see anyone or get to know the other patients. Although, doctors and nurses did come and speak with them several times a day. Another said that unless their activities were scheduled (such as physiotherapy and pool sessions) there was nothing else to do and felt that they could be doing more”. A third stated that socially they only talk to nursing staff and doctors and have limited time with other patients.
- Patients who did not like the food provided were given various options. One patient we spoke with was given space in a freezer in order to buy his own microwave meals ensuring the patient continued to eat appropriately.
- Through charitable funding the spinal treatment centre employed two recreational co-ordinators to manage activities for patients including: visits to the local race course; motorcycle events; and football matches. They also organised birthday parties and leaving parties. However, they did acknowledge that some patients did not engage.
- Patients had access to a purpose-built garden within the spinal centre called Horatio’s Garden. This garden allowed patients (including those in a bed) to access outside space in what was a beautiful environment. A room with glass walls, called the garden room, had also been built to allow patients to look out at the garden when it was cold or wet. It was run by a charity and staffed by volunteers, which meant at times it was not staffed and was therefore locked. However, patients were given access codes for the locks allowing access even when it wasn’t staffed.
- We spoke with volunteers who worked in the garden who told us that they have regular garden workshops to teach patients how to manage a garden. Patients we spoke with and staff commented that access to a garden would not suit all patients.
- Patients and carers had access to a wide range of relevant information about spinal injuries and the spinal centre. Available to patients and carers was an information booklet containing information about the hospitals facilities, additional facilities provided in the spinal centre, maps, details on staff groups and their uniforms, and a glossary of terms and abbreviations.

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Also available was a room dedicated to information provided by charities. This included information booklets, DVD's, posters, and access to computers for online materials.

- Translation services were easily accessible to all patients who required it.
- Information booklets were prepared for patients containing in depth information about pressure ulcers and their management. This booklet described the importance of good pressure management making patients more aware of the risks involved. These were given to all patients admitted to the spinal treatment centre and at outpatient appointments.

## Learning from complaints and concerns

- When asked about the management of complaints we were told that they receive very few and those which they do receive are managed by either a senior member of staff from another area or by an investigating officer from outside of the unit. There was a complaints lead in the centre.
- Both Tamar and Avon wards collected feedback from patients. A total of 79 were comments received between May and July 2015. Tamar ward accounted for 46% of all comments and Avon 54%. 62% of all comments were negative of which many related to the lack of food and drink choices, or being served cold or small portions. There were 16 comments about treatment and care of which 10 were positive. We were not informed of actions as a result of these comments.
- Patients we spoke with were unsure how to make a formal complaint. There was limited information available in the outpatient areas about making a complaint.

## Are spinal injuries centre services well-led?

Requires improvement



We rated well-led to require improvement.

Although there was a strategy document called a model of care it left patients confused and staff felt that it was

not meaningful or reflected practice in the centre. The strategy for the service, to expand with a new building, was not underpinned by detailed or realistic objectives reflecting the current health economy.

Although risks were identified through governance meetings and recorded on risk registers serious risks such as backlogs in video uro-dynamics, backlogs in outpatients, and ventilated patients requiring one to one care were identified but the pace at which improvements were made was slow.

The trust had recognised that there were some challenges for leadership within the spinal services and was providing increased support through both the medical and nursing directors. Local leadership was positive and staff felt there was an open and honest culture with positive examples of staff and public engagement including input into improvement project and the collection and analysis of staff and patient views and opinions once a project had been implemented to assess its impact on patient care.. The centre contributed to national and international innovation and research and was regularly represented at conferences.

## Vision and strategy for this service

- In October 2015 the spinal treatment centre developed a model of care presenting the care pathways they were delivering. This was developed in a format for patients to understand. Managers highlighted this to us as their strategy for the service alongside their mission statement and this was being implemented into the service at the time of the inspection. However, some staff said that patients were left confused by this. One staff member commented that the model of care and strategy were not meaningful or supported what was actually going on in the centre.
- Managers told us that the centre would soon be moving to tariff based commissioning through the specialist commissioners of NHS England. Although they do not know when this will be implemented no trajectory planning for financial stability at different tariff levels or gap analysis had been conducted or were being planned.
- Managers told us that the vision for the centre was to have a new building to improve their services and to expand capacity with a feasibility study being



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conducted alongside a business case. When inspectors asked about financing such a project managers said they would have to do a lot of self-funding for the project.

- As well as this project there were ongoing projects to improve the services they currently have. For example a capital bid had been developed to replace the pool.

## **Governance, risk management and quality measurement**

- The governance structure was clear and management staff were clear on the cascade of information both up to the board and down to ward level. On a monthly basis managers reported on their performance to the musco-skeletal governance meeting and individuals from the unit (for example the therapies lead) presented their own performance reports. Actions from these meetings were disseminated to staff on the ward through weekly staff meetings. Where items appeared on the corporate risk register reports were required for the board to analyse and action.
  - Significant issues that threatened the delivery of safe and effective care were being identified through the use of a risk register. However adequate action to manage them was not always taken.
  - Increased staff turnover and a need for recruitment since January 2013 appeared on the departmental risk register and was rated as a 12 (major risk which will probably occur). It was identified that ventilated patients required one to one nursing to ensure patient safety. However, during our inspection this was not happening increasing the risk of patient harm. When asked consultants were under the impression that the ratio should have been 1:2 which was not represented in any guidance or on their risk register.
  - Patient appointment backlog for video-urodynamics appeared on the departmental risk register and was rated as a 12 (major risk which will probably occur). Mitigating actions included booking patients in chronological order based on complexity. However, this was not happening effectively. Managers told us that they do not currently do this. Capacity of the centre, both inpatient and outpatient, appeared on the departmental risk register and rated as nine (moderate risk which is possible to occur). Mitigating action included booking patients into available clinics. There was no indication of forward planning on the risk register to increase the number of clinics available.
- However, a scoping exercise had been conducted to look into how many additional appointments were required. Managers also told us that they were going to look at ideas on how to streamline the capacity they currently have and increase capacity overall.
- We were told that there were plans in place to change the consultants job plans to increase capacity for both VUD's and outpatient appointments. However, this had been ongoing for the last two years with no change.
  - Low levels of therapy staff appeared on the departmental risk register and currently rate as six (moderate risk but unlikely to occur). Mitigating actions included the co-ordination of time and staff to minimise the impact to patients. However, there were no forward plans on the risk register to increase the staffing levels of therapy staff to manage the problem.
  - The centre had a team of people involved in governance. When we asked one key senior staff member involved in this these processes how they fit in the governance framework we were told their role was to set meeting agendas and arrange clinical governance meetings. We were told that audit information went straight from the ward managers to the central governance team as "the wards know audit better than me".
  - Managers told us that there were different management styles on Tamar and Avon wards which affected their understanding of governance. For example we were told that staff on Avon ward were less engaged with governance because the clinical manager did not discuss this with staff regularly.
  - Another example was with sharing good practice with medicines management. Tamar ward have recently got a second medicine trolley as it was found having two was proactive on Avon ward. However, Avon ward had the second trolley for two years prior to Tamar.

## **Leadership of service**

- Junior doctors felt they were well supported by consultants and that any ideas or concerns were taken seriously, acted upon and were informed of changes being made. We were told that the consultants well supported by the deputy medical director.
- Managers said that there was a positive relationship with the senior management team in the trust and felt that they were being well supported. One example was that the leadership team was identified to be weak in a mock CQC inspection performed by the trust. Support

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was provided by the director of nursing to improve this. However, one staff member commented that as a result of bed closures they were challenged by the senior team and the executive team to open them again even though it was unsafe to do so.

- We were also told that the chief executive regularly visits the centre and talks with all grades of staff. Staff we spoke with said that the executive team were approachable and would listen to what was said.
- Although there was instability in the leadership of one of the wards the local ward leadership was positive. On Avon ward the ward manager was on annual leave. However, the nurse in charge clearly knew the service well and was supportive of their staff and the duty of care required. They demonstrated positive knowledge of staffing and skill mix and recognised the need to include patients in their care and clearly led by example and valued the views of patients and relatives. They had a good knowledge of local audit and current issues and managed the staffing rota well.
- Staff nurses were offered leadership training and a workbook to develop these skills on the ward. These were knowledge and competency based and helped current and prospective leaders to develop the skills necessary for a leadership role.
- Tamar ward was being supported to improve and sustain good care during the temporary absence of the ward leader. This included weekly meetings with the director of nursing and senior staff. An action plan was created alongside these meetings with clear identification of responsibilities for changes and an audit trail of progress.

## Culture within the service

- It was clear that the staff clinically worked as a cohesive unit with the best interest of the patient at heart. Management were approachable and were visible on the wards and in outpatient areas. Staff we spoke with were overwhelmingly positive about working in the unit and were proud to be part of the spinal treatment team.
- Staff felt they were listened too and that concerns were managed where possible and that there was no worry from staff when either questioning managements decisions or suggesting improvements or ideas.

- Staff had received equality and diversity training informing all staff of their responsibilities for equal opportunities in the workplace. It was clear from discussions with management that there was no discrimination in the workplace.

## Public engagement

- The centre had close engagement with spinal injury charities who sent volunteers on a regular basis who have suffered from spinal injuries to speak with patients and deliver educational sessions. We observed a 'live it' session where an ex-patient from the service was discussing relationships with friend and co-workers after discharge and the challenges associated with this.
- The centre had developed friends and family information days where relatives and carers of patients living with spinal cord injury could learn more about the injury, symptoms and side effects of treatments, caring skills, and inform them of where to look for more information. During these sessions people were able to leave feedback with the nurses to improve the service.
- The centre had developed friends and family leaflets encouraging people to come to the department and ask questions. Every day there was a member of staff allocated to this activity and was available five days a week.

## Staff engagement

- There were weekly staff meetings which were well documented. We looked at a selection of these minutes and found the meetings were informative and used as a forum for discussion and debate for ideas and change.
- Staff had access to psychological services to manage their own health and wellbeing. Staff we spoke with found this was helpful as it gave them support when managing difficult or stressful situations.
- Staff were regularly asked about ways in which the service could be improved and were actively involved in the development of these service improvement. This information was then released as a newsletter to inform staff of the changes. These changes included the development of a trust integrated website, improvements to documentation management, a staff photo board, and an agency staff induction. During the time of the inspection there were 22 improvement projects with updates discussed.
- Staff feedback was taken when new systems were put in place. These systems were then modified to reflect

# Spinal injuries centre

concerns raised by staff. One example was with a new handover sheet which was not being used effectively by staff. The reasons for this were collected and data was analysed and changes were made based on the learning.

## **Innovation, improvement and sustainability**

- The spinal treatment centre was involved in various research programmes locally, nationally and internationally and regularly presented and hosted various spinal conferences and study days.
- The spinal treatment centre was developing a method of spinal assessment to perform more assessments in a smaller amount of time. This was being used in practice at the spinal unit and was presented at international conferences.
- The spinal treatment centre regularly attended national meetings with other spinal centres to discuss learning and trends from other centres.

# Outstanding practice and areas for improvement

## Outstanding practice

- The surgery wards had identified link roles for staff in varied and numerous relevant subjects. A nurse and a healthcare assistant had been assigned together to the link role.
- The surgery and musculo-skeletal directorates had regular specialty meetings. A member of the care staff who would not otherwise attend these meetings joined the meeting each time to provide a 'sense-check'. They listened to the content, decided if it made sense and properly described the state of their service.
- There was an outstanding level of support from the consultant surgeons to the junior and trainee doctors and other staff including the student nurses.
- The maternity services strived to learn from investigations in order improve the care, treatment and safety of patients. This was evident with the robust, rigorous and deep level of analysis and investigation applied when serious incidents occurred. For example, the reopening of a coroners case as a consequence of the maternity service investigations. Further evidence of this was available in meeting minute records. In addition, a wide range of staff demonstrated that learning from incidents was a goal widely shared and understood.
- The Benson bereavement suite facilities, and sensitive care provided to patients experiencing loss were outstanding. These services had been developed with the full involvement of previous patients and their partners. The facilities were comfortable and extensive, enabling patients and their families' privacy and sensitive personalised care and support.
- In the services for children and young people a mobile APP was produced in conjunction with a regional neonatal network to provide information and support for parents taking their babies home.
- Sarum Ward staff worked across the hospital working with a variety of teams to improve services for children and young people. Examples were of developing a DVD for pre-operative patients, using child friendly surveys in other areas of the hospital, supporting any staff with expertise on the needs of children and young people.
- Nurse led pathways were being used. In one example a nurse led pathway was in place for early arthritis, this pathway had been ratified by the Royal College of Nursing. The pathway was evidence based that showed the quicker patients were diagnosed with arthritis, the quicker treatment could be started and the quicker patients could go into remission. This service came top in a national audit for patients with early arthritis. Staff had presented their service at national and international conferences including the Bristol Society of Rheumatology conference in 2015.
- We observed excellent professionalism from staff in outpatients during an emergency situation. Staff attended to the patient that needed immediate help and support. Staff also cared and supported the other patients who had witnessed the emergency. Patients were moved away from the emergency into another department and kept informed of what was happening and offered lots of reassurance. When the emergency was over, patients were shown back into the waiting area with explanations on the subsequent delay to the clinic.
- The outpatients departments monitored how often patients were seen in clinics without their medical records. From January to July 2015 123,548 sets of patients notes were needed for the various clinic appointments across the trust. Out of these, 115 sets of notes could not be located for the appointment. The department identified that this was because the notes had been miss-filed, staff had not used the case note tracking properly or the notes were off site for another appointment. Overall, patients' medical notes were found for 99.91% of appointments, which was a small increase from the previous two years. This showed that there was an effective system in place for making sure patients' medical notes were available for their outpatient's appointments. Where they were not available, a reason was identified to try and reduce the likelihood of the issue happening again.
- In the spinal centre there were examples of care where staff went above and beyond the call of duty. One example of this was where a patient got married in the spinal centre. Staff went with the patient's partner to

# Outstanding practice and areas for improvement

collect and prepare food and on the wedding day was picked up by a member of staff in their classic car. The couple were then allowed the use of the discharge accommodation after the wedding.

- The 'live it' and 'discuss it' sessions were fully integrated into the spinal treatment centre. We observed one session where patients and relatives

were given opportunities to discuss their concerns as a peer group as well as to professionals and ex-patients. It was clear that patients and their carers were being supported through a difficult time and were being educated on important topics preparing mentally and physically them for discharge.

## Areas for improvement

### Action the hospital MUST take to improve

#### Action the hospital MUST take to improve

- Review nurse staffing levels and skill mix in the areas detailed below and take steps to ensure there are consistently sufficient numbers of suitably qualified and experienced nurses to deliver safe, effective and responsive care. This must include:
  - a review of the numbers of staff and competencies required to care for children in the emergency department,
  - a review of the arrangements to deploy temporary nursing staff in the emergency department,
  - a review of arrangements in the emergency department to ensure that nursing staff receive regular clinical supervision, education and professional development.
  - a review nursing staff levels at night on Amesbury ward, where the current establishment of one nurse for 16 patients, does not meet guidance and is not safe. Other surgery wards with a ratio of one nurse to 12 patients at night must be reviewed. Pressure on staff on the day-surgery unit, when opened to accommodate overnight patients, and still running full surgical lists, must be addressed.
  - ensuring there are appropriate numbers of, and suitably qualified staff for the number and dependency of the patients in the critical care unit.
  - ensuring there are adequate numbers of suitably qualified, competent and skilled nursing and medical staff deployed in areas where children are cared for in line with national guidance.
  - ensuring there are sufficient numbers of midwifery staff to provide care and treatment to patients in line with national guidance. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3) Regulation 18(1)
- ensuring one to one care is provided in established labour in order to comply with national safety guidance (RCOG, 2007)
- Ensure staff across the trust are up-to-date with mandatory training.
- Ensure that all staff have an annual appraisal and that records are able to accurately evidence this.
- Complete its review of triage arrangements in the emergency department without delay and take appropriate steps to ensure that all patients who attend the emergency department are promptly clinically assessed by a healthcare practitioner. This must include taking steps to improve the observation of patients waiting to be assessed so that seriously unwell, anxious or deteriorating patients are identified and seen promptly.
- Ensure staff effectively document care delivered in the patient's healthcare record at the time of the assessment or treatment in line with the hospital's policy and best practice. This must include effective documentation with regard to intravenous cannulas and urethral catheters and the recording of patients' weight.
- Strengthen governance arrangements ED to ensure that all risks to service delivery are outlined in the emergency department's risk register, that there are clear management plans to mitigate risks, regularly review them and escalate them where appropriate.
- Ensure that all actions are implemented and reviewed to reduce patients being cared for in mixed sex accommodation.
- Ensure that daily and weekly check of all resuscitation equipment are completed and documented appropriately.
- Ensure there is a hospital policy governing the use and audit of the World Health Organisation surgical safety checklist. The audit of the checklist must be



# Outstanding practice and areas for improvement

conducted as soon as an appropriate period of time has passed since its reintroduction. Results must be presented to and regularly reviewed at clinical governance.

- Ensure there is a sustainable resolution to the issue of holes or damage in the drapes wrapping sterile surgical instrument sets, and all sets are processed and available for re-use to avoid delays or cancellations to patient operations.
- Ensure patient charts are kept secure and confidential at all times.
- Must ensure there is effective management of the conflict between meeting trust targets for performing surgery and the impact this has on patients. Patients must not be discharged home from main theatres unless this cannot be avoided. Surgery must not be undertaken if there is clearly no safe pathway for discharging the patient. Operations must take place in the location where staff are best able to care for their recovery.
- Ensure staff consistently adhere to the trust infection control policy and procedures.
- Ensure that patients are discharged from the critical care unit in a timely manner and at an appropriate time.
- Ensure the process for booking patients an elective beds following surgery is improved and reduce the number of cancelled operations due to the lack of availability of a post operative critical care bed.
- Ensure that the governance arrangements for critical care operate effectively, specifically that identified issues of risk are logged and that risk are monitored, mitigated and escalated or removed as appropriate.
- Ensure that care and treatment is provided in a safe way relating to the numbers of spinal patients waiting for video uro-dynamics and outpatient appointments and reducing the risk of harm to these patients.
- Ensure that risks associated with the spinal service are managed appropriately with the pace of actions greatly improved. In particular, to the management of the numbers of patients waiting for video uro-dynamics and outpatient appointments.
- Ensure care and treatment are delivered in a way to ensure that all patients have their needs met which reflects their preferences. This includes the training of agency staff, the availability of physiotherapy and occupational therapy sessions, and the availability of suitable activities for patients.

## Action the hospital **SHOULD** take to improve

- Continue to work with third party providers to ensure that patients with mental health problems (adults, children and young people) who attend the emergency department out of hours do not experience long delays to be assessed by a mental health practitioner.
- Take steps to ensure that patients in vulnerable circumstances, such as patients living with dementia, are appropriately supported in the emergency department and the short stay emergency unit.
- Ensure staff receive sufficient training in the Mental Capacity Act in line with the trust's targets so they are up to date with the relevant guidance.
- Ensure all staff implement policy and procedures in relation to the isolation of patients with known infections and ensure staff are not isolating patients who no longer require isolation
- Ensure all paper based care plans and records are legible copies.
- Ensure urgent or unplanned medical patients are seen and assessed by a consultant within 14 hours of admission.
- Ensure patient flow within the hospital is managed appropriately so that patients are moved a minimal number of times during their stay. Ward staff and bed management teams should work effectively to ensure the need to move patients at night is minimised, in line with the trust's policy.
- Ensure that medical patients are cared for on wards to best meet their medical speciality needs.
- Ensure patient records within surgery are clear to other clinicians if there has been any issues they should be aware of, such as the risks of a retained swab, for example.
- Ensure there is a professional standard of reporting for mortality and morbidity reviews with actions being decided, recorded, monitored and improvements recognised. All high-risk deaths or those recognised as having less than optimum care or treatment should be reviewed.
- Recognise Duty of Candour within root-cause analysis reports following any serious incidents.
- Ensure there is sustained improvement in hand-washing audits for the medical staff within surgical services.

# Outstanding practice and areas for improvement

- Ensure all used surgical instruments are safely removed from operating theatres to prevent and risks from cross-contamination.
- The trust should ensure all policies are reviewed to ensure they do not discriminate.
- Ensure the results of the consent audit are addressed as some areas within surgical services criticised in 2014 had not improved in 2015.
- Ensure there is improved communication and experience for patients who are delayed for their operation. Staff should ensure patients are not fasted inappropriately, and are given updates of their progress towards surgery as often as possible.
- The trust should improve access throughout the hospital to Wi-Fi.
- Should develop an approved strategy for the surgery and musculo-skeletal directorate for the future provision of services, which should cover the vision and plans for a reasonable period into the future.
- Ensure there is consistency in reporting of departmental clinical governance meetings within the surgery directorates and all audits and reports are reviewed somewhere relevant within the governance process.
- Ensure the acknowledgement and the documentation of risk and acting upon it in emergency laparotomy procedures is significantly improved after it has been identified as poor for over a year. An integrated care pathway should be created for emergency laparotomy procedures.
- Ensure that equipment such as commodes are cleaned after use.
- Ensure that patients cutlery and crockery are decontaminated separately from staff items.
- Ensure that hand sanitising and personal protective equipment rules are consistently followed on the unit.
- Ensure that all patients with allergies are identified appropriately.
- Ensure that corridors emergency exits are always free from clutter.
- Ensure that health care records are maintained and completed contemporaneously.
- Maintain version control for documents used in healthcare records.
- Ensure that there is a dedicated pharmacist solely for Radnor Ward meeting the core standards for critical care services.
- Consider auditing the use of the newly introduced mini checklists in critical care designed to improve the documentation if ward rounds in the medical notes.
- Review the sustainability of the consultant rota in critical care unit in light of the unit becoming busier.
- Ensure that all policies and procedures in use are in date.
- Ensure that patients within critical care are regularly assessed regarding pain and document pain scores.
- Ensure that patients who are ventilated or sedated have their personal care needs attended to at an appropriate time.
- Ensure that there are systems in place to reassess staff competence in the administration of intravenous fluids and medicines in line with NICE guidelines CG174.
- Ensure that equipment training for medical staff is recorded.
- The trust should ensure that a minimum of six weeks supernumerary time is provided for newly qualified staff joining the team in line with the Intensive Care Core Standards.
- Ensure that the communication record is completed for all patients in the critical care unit and where appropriate relatives communicated with in a timely manner.
- Should ensure all medicines are dispensed and stored safely and in accordance with national and local guidelines.
- Should evidence, using a representative sample, compliance with, the World Health Organisation (WHO) adapted surgical safety checklist for obstetric theatres.
- Should ensure the gynaecology mortality and morbidity meeting minutes record attendees and contain sufficient detail to evaluate how discussions have led to learning or other actions.
- Should be aware of the processes regarding the maintenance of equipment in the maternity service.
- Should ensure all equipment used in the maternity service has in date maintenance and service checks.
- Should review the number of computer on wheels required for effective use within the delivery suite.
- Should ensure when clinical rooms are in use, that patient privacy is maximised and interruptions minimised within the maternity services.

# Outstanding practice and areas for improvement

- Should provide assurance that all midwives redeployed during busy periods have the necessary skills and competencies to work in alternative clinical environments.
- Should maximise opportunities within the maternity services for multidisciplinary team working for the benefit of patient care.
- Should consider and follow all aspects of the maternity escalation policy when there are insufficient midwives.
- Should have defined future succession planning within the maternity and gynaecology services.
- Should have access to departmental quality, governance and improvement information, which can be promptly accessed by all senior maternity staff.
- Should consider how a deteriorating patient's needs are recognised, escalated and documented within the children's and young people's service .
- Should ensure levels of safeguarding training and knowledge for medical staff is in line with national guidance within the children's and young people's service.
- Should consider the environment in which children are cared for and their exposure to adult behaviours.
- Should consider embedding the use of a staffing acuity tool within the children's and young people's service to monitor changes in staffing requirements throughout.
- Should ensure protocols are clear for staff and accurately followed so that equipment is checked as being clean and ready for use within the children's and young people's service.
- Review the arrangements for mortuary viewings at weekends and ensure clarity around staff understanding of the procedures in place.
- Ensure a trust wide policy and strategy for end of life care is developed.
- Have measures in place to make sure all outpatient areas achieve 100% in their hand hygiene audits.
- Review the haematology outpatients area to ensure patients are as comfortable as possible whilst waiting for their appointment, rather than standing in the corridors.
- Review and revise the current system in outpatients for auditing outside prescription forms to make sure it is fit for purpose and a clear audit trail of prescription forms was available.
- Ensure that it has systems and processes in place to meet the national waiting time targets including the two week cancer targets.
- Maintain one to one support and care for ventilated patients in the Spinal Treatment Centre by suitable staff to continually provide safe care for this high risk patient group.
- Alliterate the importance of call bells to all staff working in the Spinal Treatment Centre and that their roles and responsibilities to answer these calls are understood by all.
- Improve the practices of staff and processes to maintain a clean environment to reduce the risk of and spread of infections.
- Improve how it collects patient outcomes in the spinal services and use the data in a meaningful way to gain oversight of the effectiveness of care provided and to improve the service.
- Improve how it manages competence of staff within the spinal services and assures itself that oversight of staff competence is obtained.

## Requirement notices

### Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 9 HSCA (RA) Regulations 2014 Person-centred care</p> <p>(1)The provider had not taken appropriate steps to ensure that the care and treatment of service users</p> <p>(a)appropriate</p> <p>(b) met their needs</p> <p>(3) (a) the provider had not carried out, collaboratively with the relevant person an assessment of the needs and preferences for the care and treatment of the service user.</p> <p><b>Emergency services</b></p> <p>Patients did not always receive an initial clinical assessment by a healthcare practitioner within 15 minutes of arrival in ED. Guidance issued by the College of Emergency Medicine (Triage Position Statement, April 2011) states that a rapid assessment should be made to identify or rule out life/limb threatening conditions to ensure patient safety. In addition observation of patients waiting to be assessed was not adequate which reduced the opportunity to identify seriously unwell, anxious or deteriorating patients and ensure they were seen promptly.</p> <p><b>Surgery</b></p> <p>The trust was not effectively managing the conflict between meeting surgery targets and providing patients with a service that safely met their needs and gave them a good quality experience. (9(b))</p> <p><b>Critical care</b></p> <p>Patients in Radnor Ward were not discharged in a timely way from the unit onto wards when they were ready to leave or at an appropriate time. Five patients (between April and June 2015) had been moved after 22.00hours.</p>

## Requirement notices

The process the process for booking patients an elective beds following surgery did not consider the limit as to how many beds could be booked each day. In the three months to March 2015 11 elective cases were cancelled due to a lack of available post operative critical care beds.

The two corner bed spaces were restrictive. These did not provide:

- an unobstructed circulation space at the foot of each bed space to maintain the required bed separation for infection control reasons and aid positioning of equipment
- space to allow staff to manoeuvre the patient, themselves and equipment safely due to the close proximity of neighbouring bed spaces
- space to allow five members of staff to attend to the patient in an emergency situation
- space to accommodate the specialised beds that were used for the other critical care patients.

A consultant explained that the two bed spaces in question were adequate, especially for level one and two patients. However, during the inspection an intensive care (level three) patient was admitted into one of the bed spaces. A risk register was developed for the refurbishment. Insufficient space to meet current bed space recommendations was included and stated that 12 beds could be used during periods of escalation if risk assessments were undertaken to reduce risks to patients. However the issue of risk assessments was not included in the draft operational policy; neither was there a documented risk assessment for a patient cared for in one of these beds during the inspection.

### Regulated activity

Treatment of disease, disorder or injury

### Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

10(2)

The provider must ensure the privacy of the service user.



This section is primarily information for the provider

## Requirement notices

Compliance was not consistently achieved for single sex accommodation.

### Regulated activity

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

**12(1) Care and treatment must be provided in a safe way for service users.**

**12(2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include:**

(f) where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs.

#### Surgical services

There had not been a sustained resolution for the incidence of damage to or holes in the sterile surgical instrument packs so they were rendered unusable. Not all instrument packs were available when they were needed.

Care and treatment was not consistently provided in a safe way for patients.

**12(h) assessing the risks of and preventing, detecting and controlling the spread of, infections including those that are healthcare associated**

Staff on Radnor ward were not consistently adhering to the trust infection control policy and procedures:

- Commodes when found to be dirty and there was no standard cleaning procedure in place for these on the unit

## Requirement notices

- There was not a hand basin for every bed space as recommended by Health Building Note 04-02 and this was not documented on the risk register.
- Staff were not consistently using personal protective clothing such as gloves and aprons appropriately, for example, not removing and replacing these when required, or not using them at all when required.

Patients and staff crockery were being washed together. There was dishwasher in place but it had not been plumbed in due to water pressure problems.

### Trust wide

Regulation 12 (2) (e) care and treatment must be provided in a safe way for service users and without limiting paragraph one the things which a registered person must do to comply with that paragraph include – ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and used in a safe way.

The provider must make sure that equipment is suitable for its purpose, properly maintained and used correctly and safely. We found that resuscitation equipment was not being checked appropriately or within national guidance.

## Regulated activity

Treatment of disease, disorder or injury

## Regulation

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) Such systems or processes must enable the registered person, in particular, to:

## Requirement notices

(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality and experience of service users in receiving those services); and

(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of services users and others who may be at risk which arise from the carrying on of the regulated activity, and

(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

The emergency service risk register did not systematically capture the range or severity of known risks to safety and quality.

Within the emergency department there was a lack of assurance that identified risks were regularly reviewed or appropriately escalated within the organisation.

The surgery services did not have a policy or any audit data yet produced following the recent reintroduction of the surgical safety checklist. The safety of the checklist was not considered by the theatre management clinical governance.

There were potential breaches of patient confidentiality in surgery services from patients' charts on wards not being held securely at all times.

In the medical wards there was ineffective documentation with regard to intravenous cannulas and urethral catheters and the recording of patients' weight.

## Requirement notices

Some charts were illegible.

Trust wide

The governance arrangements across the trust were not consistently operating effectively. Not all identified risks were entered onto the risk register therefore they were not appropriately assessed, monitored and action taken to remove or mitigate the risk.

Risks that were on the risk register were not all reassessed and monitored, with some past their review date.

### Regulated activity

Diagnostic and screening procedures

Treatment of disease, disorder or injury

### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

**18(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.**

**18(2) Persons employed by the service provider in the provision of a regulated activity must –**

**(a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.**

There were not always sufficient numbers of suitably qualified, skilled and experienced nursing staff in the emergency department.

There were insufficient numbers of staff employed in the emergency department who had received appropriate training to equip them to care for children.

## Requirement notices

Compliance with mandatory training in the emergency department was well below the trust's target rate of 85%.

There was a lack of assurance that nursing staff in the emergency department had sufficient opportunities for clinical supervision, education or professional development.

Arrangements for the deployment of temporary staff in the emergency department were not sufficiently robust to ensure that these staff were suitably skilled or experienced.

Nursing staffing levels in surgery services had not been adequately reviewed and, although were improving, were not yet established to safe levels. There were some areas where staff anxiety and stress were high due to feeling unable to carry out their duties to a high standard.

Staff employed in surgery services had not met trust targets for updating mandatory training. Non-medical staff in surgery services had not met the trust targets for being provided with an annual performance appraisal.

Occasionally due to staffing shortages, the unit did not maintain safe nurse staffing levels in accordance with the NHS Joint Standards Committee (2013) Core Standards for Intensive Care. The details of these occasions were not documented. However, the electronic reporting system was used to highlight shifts that were short staffed. There were 16 flagged short staffed shifts between August 2015 and November 2015.

There were not sufficient numbers of midwifery staff to provide care and treatment to patients in line with national guidance.



## Requirement notices

There was a lack of assurance that there was sufficient staff in maternity services to provide one to one care in established labour 100% of the time. This was required to be compliant with national safety guidance (Royal College of Obstetricians and Gynaecologists, 2007)

There were not enough Registered Nurses (child branch) available to meet the changing dependency needs of patients in the children's services at all times.

There were not enough junior doctors in the children's services to cover the needs of all areas caring for children at evenings and at weekends, according to the British Association of Perinatal Medicine guidelines.

Trust wide

Staff were not receiving annual appraisals and the documentation to support the number of staff who had was poor.

Staff were not all up to date with mandatory training.

## Enforcement actions

### Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Section 29A HSCA Warning notice: quality of health care</p> <p>Care and treatment are not being provided in a safe way for service users.</p> <p>Systems or processes have not been established and are not operating effectively to:</p> <ul style="list-style-type: none"><li>a) assess, monitor and improve the quality and safety of the spinal services provided;</li><li>b) assess, monitor and mitigate the risks relating to the health, safety and welfare of spinal service users.</li></ul> <p>Patients in spinal services were frequently and consistently unable to access services including video uro-dynamics and outpatients in a timely way for diagnosis, follow up and treatment and experiences unacceptable waits for these services. There were 467 patients on a waiting list for video uro-dynamics and 1,024 patients on a waiting list for an outpatient appointment with no clear understanding from the trust as to how the risks to these were assessed. There were no clear and detailed actions with timescales to reduce these lists.</p> <p>Effective measures to reduce or remove the risks relating to the wait for video uro-dynamics had not been introduced. In addition there was a lack of processes to minimise the likelihood of risks and the risks of any impact on patients.</p>