

Dartford and Gravesham NHS Trust

Darent Valley 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

Accident and emergency	Requires improvement	
Medical care	Good	
Surgery	Requires improvement	
Intensive/critical care	Good	
Maternity and family planning	Good	
Services for children & young people	Good	
End of life care	Good	
Outpatients	Good	

Summary of findings

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Summary of findings

Overall summary

The ratings in this report were awarded as part of a pilot scheme to test CQC's new approach to rating NHS hospitals and services.

Darent Valley Hospital offers a comprehensive range of acute hospital-based services to around 270,000 people in Dartford, Gravesham, Swanley and Bexley. The hospital opened in September 2000. The hospital building is run as part of a private finance initiative. This means the building is owned by The Hospital Company (Dartford) Limited, a private sector company, and the trust leases the building. Darent Valley Hospital now has around 463 inpatient beds and specialties that include day-care surgery, general surgery, trauma, orthopaedics, cardiology, maternity and general medicine. The hospital has a team of around 2,000 staff.

Dartford and Gravesham NHS Trust was selected as part of the Chief Inspectors of Hospitals' first new inspections as a trust considered to be in the middle ground between low and high risk of poor care. This inspection focused on Darent Valley Hospital.

Dartford and Gravesham NHS Trust is registered for the following regulated activities to be provided at Darent Valley Hospital:

- Diagnostic and screening procedures
- Maternity and midwifery services
- Surgical procedures
- Termination of pregnancies
- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury.

Since the trust registered with the Care Quality Commission (CQC) in 2010, Darent Valley Hospital has been inspected four times. At the last inspection in November 2012 the trust was found to be compliant with all regulations inspected.

Our inspection team included CQC inspectors and analysts, doctors, nurses, patient 'experts by experience' and senior NHS managers. Experts by experience have personal experience of using or caring for someone who

uses this type of service. The team spent two days visiting the hospital, and two further unannounced visits were conducted the following week. One of these included an evening/night time visit.

Maternity, outpatients, children's services and end of life care were found to be good. In all services across the hospital, most staff were committed to the trust and said it was a supportive environment to work. Patients were generally positive about their experience and the care they received.

The trust faced challenges after the recent collapse of merger plans, and it had not yet developed an alternative vision for the organisation. There were a number of examples of good practice and examples of shared learning in the hospital, although in some cases the changes in practice in response to learning from serious incidents took up to 12 months to implement. The main challenge was the demand on the accident and emergency (A&E) department and the rise in emergency admissions. A significant causal factor had been the recent reduction of acute services in the immediate vicinity. The trust was managing issues on a day by day basis but not solving the key underlying problems, in particular bed management/capacity and inappropriate attendance at A&E. It is acknowledged that the trust cannot solve these problems on its own, as they will require a whole healthcare community approach.

The trust had taken action in some areas where staffing issues had been identified. This had included increased nursing staff levels on some wards, an increase in the number of porters in the pharmacy department and the recruitment of additional midwives. In A&E there were insufficient numbers of nurses qualified in the care of children and a high use of locum middle grade doctors, which had the potential to impact on patients' safety.

Patients' dignity was being compromised by the continued use of mixed sex wards and facilities in the Clinical Decision Unit where staff told us they always have mixed sex accommodation and the Medical Assessment Unit, which we observed as a mixed sex ward. This also occurred in the intensive care area when patients no longer required intensive care. Patients' right to privacy was being compromised by personal information being

Summary of findings

on display in open areas, for example on computer screens in the A&E and confidential information being discussed in public areas such as corridors. The area in the operating theatre where people were received into the department also compromised patients' privacy and dignity, as it was an open area. Since April 2011, the hospital's bed occupancy rate had consistently been above the national average of 86.5%, rising as high as 96.1% for the period of Apr-Jun 2013. This was impacting on patient safety through the use of additional beds in areas not designed or equipped for this purpose.

In some areas, the trust was considering and implementing national guidelines, but in A&E we found guidance was not always being followed, for example with the management of children's pain. Also some of the guidance that was available was not the most current

such as resuscitation guidelines. Staff told us that the trust was a supportive environment in which to work and that training was available, though the trust's own training records showed that attendance at the trusts mandatory training was below the trusts expected level. This was low as 66% in some areas compared to the trusts target of 85%. There was a system in place to monitor attendance at the trust's mandatory safety training and follow up non-attendance, but this was ineffective in some cases. There were 285 members of staff whose training was out of date and were not booked to attend a session.

Overall, we found a culture where staff were positive, engaged and very loyal to the organisation. The staff and management were open and transparent about the challenges they faced.

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

Medical care, surgery, critical care, maternity, end of life care and outpatients were found to be safe. In other areas staff told us that patient's safety was sometimes being affected by the hospital's high bed occupancy and the use of additional beds in areas not designed to be used for patient care. The trust had identified challenges with staffing, and in some cases it had taken action to address the issues. However, concerns remained in the accident and emergency (A&E) department, where there were insufficient nurses qualified in the care of children and a high use of locum middle grade doctors. This had the potential to have an impact on patient safety. Care pathways had been implemented to manage the risks associated with pressure ulcers, venous thromboembolism and urinary tract infections. Most staff were clear about their responsibilities to report incidents, though in some areas staff felt that they did not hear about the outcomes of these. The trust investigated serious incidents and produced reports and action plans. However, it could take the trust up to a year to implement learning. Patients were also being placed at risk in the A&E department due to the layout of the triage facilities in the minors area, the area where people walk in to the department and the lack of clear signage. This meant that patients' needs may not have been addressed in a timely manner as they had not been triaged or booked into the department. We had no concerns about the way patients were triaged in the majors area of the department.

Are services effective?

Maternity, outpatients, children's services, medical care, surgery, intensive care and end of life care were found to be effective. The integrated discharge team had developed good links with the community and the hospital social services department. This was helping to ensure effective discharge planning for patients on all inpatients areas. In A&E, pain relief was being well managed and assessed for adults but not for children, meaning that effectiveness was not being monitored in line with national guidelines. Guidelines in some areas had been reviewed and updated. However, in A&E there was guidance that was out of date or not the most current version and therefore not in line with national or good practice guidance which had the potential to impact on the effectiveness of care and or treatment. The trust had introduced new initiatives to help with the care and support of patients with dementia that had been effective.

Summary of findings

Are services caring?

Maternity, outpatients, children's services, medical care, surgery, intensive care, accident and emergency and end of life care were found to be caring. Patients in all areas told us that they were well cared for, received the information they required and that their questions were answered. In all areas we observed a caring approach from most staff. We also observed that there was a dementia buddies scheme in place supported by volunteers.

Are services responsive to people's needs?

The trust demonstrated that it had responded to a number of different issues in order to ensure that people got the treatment and care they needed. These included: the need to ensure effective, safe and timely discharge; staffing levels; the care of patients with dementia; and safe use of naso-gastric tubes. Of concern was that the hospital bed occupancy levels had been consistently been above the national average of 86.5%, rising as high as 96.1% for the period of Apr-Jun 2013. The trust was actively reviewing its current position, had implemented a number of actions including opening additional beds and was looking to ways to create a sustainable trust for the future. Though there was still the potential for patient's to be placed at risk if they could not be cared for in the right area to ensure their needs were met in a timely way. There was a complaints system in place, and it had been reviewed in recognition that the trust had not been consistently responding to complaints in a timely way.

There were occasions when we saw that patients' privacy was not always respected with personal and confidential information on display. For example, in open areas in the A&E on computer screens and discussions were witnessed taking place in open areas and in areas other than the wards where they could be overheard. In the medical assessment unit and the intensive care unit, patients were being cared for on mixed sex wards and in some areas had to share bathroom facilities with members of the opposite sex. Those people no longer in need of intensive care but not able to move to a general ward also had their dignity compromised by the lack of bathroom facilities available on the unit.

In addition we were concerned that patient's privacy and dignity was not always respected in the operating theatre. This was because the area where patients were received in to the department was open and more than one patient could be in this area at any one time. We were also concerned by some of the practice observed around the consenting of patients for surgical procedures.

Are services well-led?

The trust faced challenges following the recent collapse of the merger plans, and it had not yet developed an alternative vision for

Summary of findings

the organisation. There were a number of examples of good practice and examples of shared learning in the organisation. However, in some cases changes in practice in response to learning from serious incidents took up to 12 months to implement. Although senior staff felt that there was an emerging vision, this had not yet been formally agreed. There was said to be a strong executive team that was visible throughout the trust which was supported by staff. The executive team had a clear understanding of the key risks in the organisation, particularly the current situation in A&E and the trust's occupancy levels. The trust had implemented a number of actions, but there had not been any clear measurable improvements. There were no clear timelines with projected outcomes and impacts.

Summary of findings

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

Accident and emergency

We found that A&E had the potential to be unsafe as there were insufficient numbers of appropriately skilled staff to deliver care. This was because there were not enough nurses qualified in the care of children and the medical staff team was not staffed to the agreed capacity and skill mix. The triage system in the minors area led to some patients' needs not being assessed a timely manner as it was not clear that patients were required to wait to attend triage in one area and then book in and wait in another area. Staff were not always able to access current national and best practice guidelines to deliver safe effective care. Staff were caring and responsive about patients' needs but did not always maintain patient privacy. We observed examples of good individual leadership at department level but there was evidence that ongoing safety issues, for example insufficient substantive staffing, had not been resolved at a higher level.

Requires improvement



Medical care (including older people's care)

Overall, the standard of care and treatment in medical care was good. Teams were well led and supported by leaders at all levels in the service. Staff were listened to and had access to specialist training. There was positive feedback from the patients, relatives and visitors who we spoke with. They described caring and responsive staff who met their treatment needs. On a number of wards changes had been introduced in October 2013. These included increased staffing numbers. During our visit we could see that improvements were taking place. However, there had been insufficient time for many changes to have become embedded. This meant that the hospital was still improving against current performance indicators. Patient records were generally up to date with full details available to ensure that staff could provide safe and consistent care. The use of window bays, witnessed during the unannounced visit, showed that there was pressure on the hospital to cope with the level of demand. Staff were concerned about the use of 'window bay beds' and the potential impact on quality and safety.

Good



Surgery

Patients generally received safe and effective surgical care. We saw that some wards worked with fewer staff than needed. However the trust was aware of this and recruitment had taken place. A number of staff were due to commence employment in the new year. There was a multidisciplinary approach to providing effective patient care.

Requires improvement



Summary of findings

Staff we observed were caring. However, patients' privacy and dignity were not always maintained. Staff responded appropriately to changes in patients' care and treatment. Staff told us how they responded to the increased workload when admission numbers increased, particularly when extra beds were placed on the ward. However, actions the trust was taking to respond to fluctuating demands of the organisation did not prevent these situations reoccurring. Staff told us they worked in a well-led organisation. They told us the culture was open and transparent, and there was a clear willingness by all staff to learn.

Intensive/critical care

We found that the intensive care and critical care service was safe and effective, performing within expectations for a unit of its size according to the Intensive Care National Audit and Research Centre data. It was responsive to the needs of patients and had caring and attentive staff. We found that the unit was well led. Pressure was placed on the unit when transfer of patients was delayed due to bed occupancy challenges faced by the trust. Though the unit coped with the situation, these patients were cared for in a mixed sex environment and had to use the bathroom and toilet facilities in the adjacent ward.

Good



Maternity and family planning

We found that the midwifery unit provided safe and effective care for women. Feedback from women using the service was positive. They told us that staff were kind and sensitive to their needs and that they were given effective advice and support in their chosen method of feeding their babies. The service was well led with clear shared goals and objectives which were known to all staff we spoke with. Women said they had been well supported throughout their stay in the maternity services.

Good



Services for children & young people

In the main children's department parents told us that staff were responsive to their needs and that they listened to them. They were included in decisions about the care and treatment of their children. They said staff responded quickly to requests for assistance. Patients received safe and effective care and treatment. The environment was well maintained and engaging for young people. There were sufficient numbers of staff on the wards and in the outpatient area, and there was a system for the management of staffing levels and skill mix to ensure children were cared for safely.

This was not the case in the A&E department where there was an insufficient number of nurses qualified in the care of children. We also found in the A&E department that national guidance was not being followed in relation to the management of pain in children.

Good



Summary of findings

The trust was monitoring the quality of the service and making changes where they were needed. The views of children and families were being used to inform the service provision in the main children's department. There was a team in place to monitor and address any safeguarding concerns, and the trust had planned further developments.

End of life care

We found that end of life care provided at the trust was safe, effective, caring, responsive and well led. The trust no longer used the Liverpool Care Pathway and was in the process of reviewing its end of life pathway. The palliative care team worked closely with staff on wards to ensure that patients had individualised end of life care provided in a positive, supportive environment. The team also had close links to community services. Patients and their families were involved in decisions about care and treatment in a dignified, respectful manner. Staff spoke positively about the support they received from the team. They felt this improved the patient experience and ensured patients received choices regarding end of life care and treatment.

Good



Outpatients

The main outpatients department was a large area, with good access and seating for patients. Patients received effective treatment and information and felt happy with the care they received. The trust was monitoring appointment targets for waiting times and clinic start and finish times. It had sought the views of patients, and we saw that it had listened and responded to patient feedback by changing the layout of the department. Clinics were well managed and organised. When unavoidable delays occurred and clinics ran late, staff kept patients informed and provided them with information. Staff told us that they received training and supervision to enable them to provide effective care. All staff we spoke with told us that outpatients was a positive environment to work in.

Good



Summary of findings

What people who use the trust's services say

In September 2013, 406 people completed the inpatient Friends and Family Test, which asks patients if they would recommend services to people they know. Of these, 95.1% were either 'likely' or 'extremely likely' to recommend the ward they stayed in to friends or family. Some 662 people completed the test for A&E. Of these 96.1% of patients were either 'likely' or 'extremely likely' to recommend the trust's A&E department to friends or family.

In CQC's Adult Inpatient Survey 2012 the trust performed about the same as other trusts in the nine areas of

questioning. However, it performed worse than other trusts in the 'Hospital and Ward' area. The trust was in the bottom 20% nationally for four of the questions relating to poor choice of food, assistance with eating meals and sharing facilities with members of the opposite sex.

In the 2012/13 Cancer Patient Experience Survey the trust performed in the top 20% of trusts in four questions. They performed within the bottom 20% of all trusts nationally for 19 out of 64 questions.

Areas for improvement

Action the trust **MUST** take to improve

- The trust must ensure that the required number of staff with the correct skills are employed and managed shift by shift, to demonstrate that there are sufficient staff to meet people's needs.

Action the trust **SHOULD** take to improve

- The trust needs to ensure that learning from the reporting of incidents is cascaded and that any changes to practice required following a serious incident are implemented in a timely manner.
- Patients should be treated with dignity and respect at all times, particularly in the area of the operating department where patients are received.
- Patients' privacy and right to confidentiality should be respected at all times. Staff need to be more careful in making sure that confidential information is not seen and heard by others.
- The trust must ensure that at all times patients are cared for in a safe environment that is designed to meet their needs. It needs to consider the use and management of escalation beds in response to challenges with the higher-than-average occupancy levels, which, in turn, is impacting on the trust's use of mixed sex accommodation.
- The trust should take action to ensure that good practice guidance is being considered and used in all

areas of the trust, particularly A&E. The trust should also ensure that children's pain relief is administered and the effectiveness monitored in line with good practice guidelines.

- The trust should review the plans with the local healthcare community to ensure that patients needing emergency care are managed safely and effectively.
- The trust should develop an agreed vision with identified timelines and projected outcomes and impacts.

Action the trust **COULD** take to improve

- While the trust had a relatively high compliance with attendance at its mandatory training, the actual attendance levels were generally below the trust's desired level. Their own monitoring system was not always ensuring attendance. The trust could review the actions taken for non-attendance at mandatory training.
- The trust needs to ensure that nursing staff are not disturbed when administering medication.
- The trust could ensure that all staff have an awareness of the Mental Capacity Act.
- The trust needs to ensure that it follows good practice with regards to the consenting of patients prior to surgical procedures.

Summary of findings

Good practice

- An integrated discharge team had been introduced to help with the safe, effective and timely discharge of patients.
- The number of midwives had been increased and changes had been made to the environment in the maternity unit to meet the needs of women and their partners using the service.
- The hospital's bed management meetings were multidisciplinary and included executive team members and ward sisters to ensure trust-wide understanding and involvement in the decision-making process.
- End of life care provided at the hospital was safe, effective, caring, responsive and well led.
- There was a positive approach to managing the needs of people with dementia. Consideration had been given to good practice guidelines and recommendations. On the ward where most people with dementia were cared for, environmental changes had been made. There was a Dementia Buddies scheme in place supported by volunteers.
- A code of conduct for nursing assistants had been developed and launched in the trust.

Darent Valley Hospital

Detailed findings

Services we looked at:

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

Our inspection team

Our inspection team was led by:

Chair: Pete Cavanagh, Consultant Radiologist, Taunton and Somerset NHS Foundation Trust.

Team Leader: Lisa Cook, Care Quality Commission (CQC).

The team included CQC inspectors and analysts, doctors, nurses, patient 'experts by experience' and senior NHS managers. Experts by experience have personal experience of using or caring for someone who uses this type of service.

The team included a medical director, two consultants and a junior doctor. The nurses on the team came from a variety of backgrounds including critical care and surgery. The team was further complemented by a senior manager from the acute sector and a representative from Health Education England. There were also four experts by experience.

Why we carried out this inspection

We have inspected this trust as part of our first wave of 18 NHS Trusts to be inspected using our new in-depth inspection programme. Collectively these trusts represent the variation in NHS hospital care according to our 'intelligent monitoring' information. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations. We identified six trusts that were a priority for inspection because they had high risk scores. There were a further six that our model indicated as low risk, and six others between these extremes. Dartford and Gravesham NHS Trust was considered to be between the high- and low-risk trusts.

How we carried out this inspection

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

- Is it safe?
- Is it effective?

Detailed findings

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

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

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

Before visiting, we reviewed a range of information we hold about the trust and asked other organisations and key stakeholders to share what they knew about the trust.

In order to gather peoples' views we held a focus group with volunteer groups before our visit and hosted a listening event during the visit. At the time of the visit we spoke to patients and their families.

We carried out an announced visit on 5 and 6 December 2013. We observed care which included staff and patient interaction, reviewed patient and care records and spoke to a number of staff. We held focus groups for:

- Student nurses and healthcare assistants/nursing assistants
- Consultants
- Matrons
- Registered nurses and midwives
- Administrative and other staff
- Support staff
- Allied healthcare professionals
- Junior doctors.

We also conducted a number of interviews with key personnel including the Chair, Chief Executive Officer, the Chief Operating Officer, the Medical Director and the Director of Nursing. In addition to this we interviewed directorate leads and staff with key responsibilities for safeguarding, discharge planning and site management.

We carried out two additional unannounced visits, one on Monday 9 December 2013 out of normal working hours on the evening /night and another on Friday 13 December during the normal working day.

We placed comments boxes around the hospital and received 30 comments from people who used the service and staff.

Are services safe?

Summary of findings

Medical care, surgery, critical care, maternity, end of life care and outpatients were found to be safe. In other areas staff told us that patient's safety was sometimes being affected by the hospital's high bed occupancy and the use of additional beds in areas not designed to be used for patient care. The trust had identified challenges with staffing, and in some cases it had taken action to address the issues. However, concerns remained in the accident and emergency (A&E) department, where there were insufficient nurses qualified in the care of children and a high use of locum middle grade doctors. This had the potential to have an impact on patient safety. Care pathways had been implemented to manage the risks associated with pressure ulcers, venous thromboembolism and urinary tract infections. Most staff were clear about their responsibilities to report incidents, though in some areas staff felt that they did not hear about the outcomes of these. The trust investigated serious incidents and produced reports and action plans. However, it could take the trust up to a year to implement learning. Patients were also being placed at risk in the A&E department due to the layout of the triage facilities in the minors area, the area where people walk in to the department and the lack of clear signage. This meant that patients' needs may not have been addressed in a timely manner as they had not been triaged or booked into the department. We had no concerns about the way patients were triaged in the majors area of the department.

opened additional beds at a nearby location. This ward opened in October, and in November the department used 75 fewer escalation beds than in the previous month. Therefore, this initiative appears to have had a positive impact. However, the trust was still using some escalation beds in window bays, and it had not been able to completely remove the risks related to this.

Patients in the A&E department were being placed at risk, as the triage facilities were not clearly signed and some patients waited in the wrong area.

Management of pressure ulcers

Information we reviewed prior to our visit indicated that the most common type of serious incidents were pressure ulcers (grades 3 and 4). The trust's proportion of patients with new pressure ulcer cases, for all patients and for patients over 70, had fluctuated around the England average. However, both had breached the national rate in the summer of 2013.

We saw that patients were assessed for the possibility of a break in skin integrity that could lead to a pressure ulcers and that management plans were put in place. In particular, pressure relieving mattresses were being used on the orthopaedic wards. The tissue viability nurse was involved in the management of any pressure ulcers and the development of suitable treatment plans. The hospital was actively working to manage the risk of pressure ulcers.

Venous thromboembolism (VTE)

Information from the safety thermometer indicated that the proportion of patients for new venous thromboembolism (VTE) cases had fluctuated above and below the England average, with some spikes. We found that there was a system in place to assess a patient's risk factor for the development of a VTE and that this included the appropriate management or treatment option. Pharmacists confirmed that they monitored the use of the assessment tool.

Urinary tract infections

The trust's total rate for new urinary tract infections among patients with a catheter had been above the England average for much of the period August 2012 to August 2013, reaching a peak of 1.22% in December 2012 and January 2013. For patients over 70 the trust's catheter and UTI rates followed a similar pattern to that of all patients, with

Our findings

Occupancy levels

The hospital had a bed occupancy consistently above the national average of 86.5%, rising as high as 96%. A causal factor in this was the closure of other local services. Historically the trust had been using additional beds in window bays (escalation beds) to manage peaks in demand. The number of additional beds in use per day had varied between two and nine. Staff report that the use of these beds compromised both patient safety and the quality of care, as these areas were not designed or equipped to take patients. In response to this, the trust had

Are services safe?

regular spikes above the England average. We saw there were systems in place to maximise patient safety. These included pathways designed to reduce the risk of patients developing catheter-related urinary tract infections.

Management of incidents

Before our visits, interested parties and stakeholders raised concerns about the trust's approach to ownership and the reporting of incidents, serious incidents and never events (mistakes that are so serious they should never happen). The concerns related to classification of incidents, the standard of investigation undertaken in response to them, and post incident learning. Most staff were clear about their duty to report incidents, and they told us that learning was shared and cascaded. We reviewed three root cause analyses and found that in two cases there had been a detailed investigation; in the third case the information was limited. In all three cases it had taken the trust a long time (up to 12 months) to implement changes to practice in response to learning. This potentially had left patients at risk.

Safeguarding

There were adult and children safeguarding policies in place. Training for all staff was included in the induction training and in the mandatory bi-annual 'Managing risk in the workplace' training. Additional, higher-level training in safeguarding vulnerable adults was available to senior managers. We saw that the trust had considered the possibility of one incident being an adult safeguarding concern. It had made and documented appropriate referrals. There was a named lead nurse for safeguarding adults, though their role was multi-faceted. We saw that there were plans to introduce a new post that would have a greater focus on adult safeguarding.

There was a changing picture for the management of safeguarding children, with plans to introduce a dedicated lead at senior level. At the time of our inspection the role was incorporated into the matron's role, supported by a nurse with responsibility for safeguarding. There was also a safeguarding children's team, which was said to visit the children's ward, maternity and the special care baby unit on a daily basis. There was an established system for informing health visitors when a child had been admitted to hospital, and attendance at A&E was monitored. We saw that there was a system to ensure that any child who had a child protection plan in place was known to the trust.

A large number of staff we spoke with were not sure of their responsibilities in relation to the mental capacity act (MCA) and the Deprivation of Liberty Safeguards. Despite this, records provided by the trust showed that 97.4% of medical staff in training and 89.2% of non-trainees (consultants and trust grade medical staff) had completed MCA training. In addition to this, 69% of nursing staff had completed the dementia cognitive impairment training, which included MCA. Additional training was also available through the local council. We saw examples on both the medical and surgical wards of consideration being given to a patient's capacity to make decisions and one example where an application to deprive someone of their liberties had been made. This demonstrated that some staff did have an awareness of the need to consider a person's capacity and the process to follow where concerns were identified. Care plans also included prompts to consider the mental capacity act.

Infection control

In the staff survey the trust was rated as 'tending towards worse than expected' for the availability of handwashing materials. We saw that handwashing facilities were readily available, as was hand cleansing gel. We saw staff and visitors using these facilities, though in the A&E department a member of staff had contact with four patients before cleaning their hands. Staff were observed to be adhering to the 'bare below the elbow' policy. The premises were generally found to be clean and tidy. There was an episode of diarrhoea on one ward at the time of our visit and the trust responded quickly, taking appropriate action.

Discharge planning

The hospital had introduced an integrated discharge team. We received positive feedback from the wards about the team and observed that they had a key role in managing the bed occupancy levels of the hospital and the safe discharge of patients. For example it had been identified that there were three community beds available and no patients were thought to be suitable for discharge to these beds. The discharge team communicated with and visited the inpatient areas and patients that would be suitable were identified.

Staffing

The national stroke audit identified that the trust had below median rates for occupational therapy, speech and language therapy and physiotherapy for stroke. An occupational therapist told us that they had put together a

Are services safe?

business case for increased support for patients who had suffered from a stroke. Information from the trust demonstrated that it was actively reviewing the nursing establishments on the wards and where required action was being taken. Specific concerns were raised about the staffing in A&E. A nurse consultant had been appointed, as had additional nurse practitioners. There were insufficient numbers of nursing staff trained in the care of children in the department and there continued to be vacancies for

medical staff and a high use of locum middle grade doctors. This impacted on the level of risk in the department. An additional porter had been employed to support the pharmacy, as this had been recognised as a risk area if medication was not always delivered to the wards in a timely manner. The number of midwives to births had been increased in response to a change in demand and to ensure safe quality care.

Are services effective?

(for example, treatment is effective)

Summary of findings

Maternity, outpatients, medical care, surgery, intensive care and end of life care were found to be effective. The integrated discharge team had developed good links with the community and the hospital social services department. This was helping to ensure effective discharge planning for patients on all inpatients areas. In A&E, pain relief was being well managed and assessed for adults but not for children, meaning that effectiveness was not being monitored in line with national guidelines. Guidelines in some areas had been reviewed and updated. However, in A&E there was guidance that was out of date or not the most current version and therefore not in line with national or good practice guidance which had the potential to impact on the effectiveness of care and or treatment. The trust had introduced new initiatives to help with the care and support of patients with dementia that had been effective.

Our findings

Pain relief

The College of Emergency Medicine audits raised concerns about the management of pain relief for both adults and children in A&E. We found that adults were receiving pain relief in a timely manner and effectiveness was being monitored. This was not the case for children; while they were receiving pain relief the effectiveness was not being monitored.

Stroke pathway

Prior to our visit, the trust has been identified by the care quality commission as having one composite indicator, Cerebrovascular Conditions, as a 'risk'. On 13 December 2013 we visited the ward where patients who had suffered a stroke were cared for. We found that there was a clear pathway for patients to follow which included multidisciplinary team involvement and there was a system in place for the stroke team to be notified when a patient was admitted to the A&E department, which meant that the pathway could be implemented without delay. We were told by staff that on occasions the availability of staff impacted on how quickly patients could be seen in the A&E department.

National guidelines

We saw that following an incident the guidelines on naso-gastric tube insertion and management of people with a naso-gastric tube had been reviewed and amended. Staff were well informed and were able to demonstrate that the revised guidelines were being followed. In the A&E department we found that some guidance was out of date and staff were not aware of any system to ensure that these were kept current or where to source the most current guidance. This had the potential to have an impact on the effectiveness of care.

Staff told us about the 'six Cs' for nursing staff: communication, care, courage, compassion, commitment, and competency. These had been used to inform the nursing and midwifery strategy. Nursing and medical staff told us that there were involved in audits and we saw that outcomes of these were discussed at governance or risk and audit meetings. The trust had also adapted the safety thermometer for assessing harm free care and information relating to this was seen to be displayed in ward areas.

In the Adult Inpatient Survey 2012, the trust was worse than other trusts for the 'Hospital and Ward' area. Two of these areas related to food, including choice and help with eating. We found that the menus had been reviewed and that mealtimes were protected to try and prevent unnecessary interference. In most cases, people were receiving help where it was required. The trust had taken action in response to concerns and made changes to try to offer a more effective service.

Discharge planning

The hospital had introduced an integrated discharge team. This team was actively involved in the discharge planning for patients. It attended a daily meeting with the social work team to review the current situation and worked closely with the community. It also attended the post take ward round with the medical staff and liaised with the wards to ensure that complex discharge planning began in a reasonable time frame. When staffing allowed, it also had staff in the A&E department to identify people who could be discharged quickly and prevent unnecessary admissions. The trust was actively working to ensure that people were discharged in safe and effective way. To further support effective discharge planning, there was a hospital at home team and a surgical bridging team that supported people at home until they could be fully discharged to their GP or other community services.

Are services effective?

(for example, treatment is effective)

Caring for people with dementia

There was a positive approach to managing the needs of people with dementia. Consideration had been given to best practice guidelines and recommendations. On the ward where most people with dementia were cared for, environmental changes had been made. These included colour coded bed bays, and toilet seats that were a

different colour to the toilet pan. Patients with dementia all had a 'This is me' document in place so that staff understood the patient's history and background. A team of 'dementia buddies' had also been introduced. Buddies were introduced to people with dementia and they would sit with them and read with them or support them in an activity.

Are services caring?

Summary of findings

Maternity, outpatients, children's services, medical care, surgery, intensive care, accident and emergency and end of life care were found to be caring. Patients in all areas told us that they were well cared for, received the information they required and that their questions were answered. In all areas we observed a caring approach from most staff. We also observed that there was a dementia buddies scheme in place, supported by volunteers.

Our findings

Patients told us that they were well cared for, that they received the information they required and that their questions were answered. One person said, "I have had the

best care from everyone who looked after me. Happy staff and a wonderful environment. All made sure I was safe and gave me reassurance when I needed it. My questions were answered and my stay here was made as nice as possible." A second person said, "The staff have been friendly and approachable and have provided very good care. They have been able to answer questions and provide information on the treatment when requested. The ward is kept clean and well maintained giving a good hygienic appearance. Overall I believe that the care has been efficient and appropriate."

Records

Patient records we viewed demonstrated that people had been involved in their care. Risk assessments had been used to inform care planning, and specific care pathways were in place for some areas such as the prevention and management of pressure ulcers and urinary tract infections.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The hospital demonstrated that it had responded to a number of different issues in order to ensure that people got the treatment and care they needed. These included: the need to ensure effective, safe and timely discharge; staffing levels; the care of patients with dementia; and safe use of naso-gastric tubes. Of concern was that the hospital bed occupancy levels had been consistently been above the national average of 86.5%, rising as high as 96.1% for the period of Apr-Jun 2013. The trust was actively reviewing its current position, had implemented a number of actions including opening additional beds and was looking to ways to create a sustainable trust for the future. Though there was still the potential for patient's to be placed at risk if they could not be cared for in the right area to ensure their needs were met in a timely way. There was a complaints system in place, and it had been reviewed in recognition that the trust had not been consistently responding to complaints in a timely way.

There were occasions when we saw that patients' privacy was not always respected with personal and confidential information on display. For example in open areas in the A&E on computer screens and discussions were witnessed taking place in open areas and in areas other than the wards where they could be overheard. In the medical assessment unit and the intensive care unit, patients were being cared for on mixed sex wards and in some areas had to share bathroom facilities with members of the opposite sex. Those people no longer in need of intensive care but not able to move to a general ward also had their dignity compromised by the lack of bathroom facilities available on the unit.

In addition we were concerned that patients' privacy and dignity was not always respected in the operating theatre. This was because the area where patients were received into the department was open and more than one patient could be in this area at any one time. We were also concerned by some of the practice observed around the consenting of patients for surgical procedures.

Our findings

Bed occupancy

The trust was aware of the challenge it faced with regards to bed occupancy levels, which were consistently above the national average of 86.5%, rising as high as 96.1% for the period of Apr-Jun 2013. The site team had oversight of bed management. There was a clearly established system in place to monitor both bed occupancy and expected discharges. We saw that this was managed through multidisciplinary bed management meetings. These were held at least three times a day, and the midday meeting involved the ward sisters. This meant that key people were informed of the current situation and involved in discussion and decisions about the management of the bed situation. The trust was aware of, and well informed about, the challenges it faced with occupancy, and we saw that senior staff took an active interest in the ongoing and ever changing situation.

While some patients were admitted to wards that were not the lead for the speciality they required, the situation was monitored and patients moved when possible. However, patient's no longer requiring intensive care had spent up to seven days waiting for a bed on a general ward. Information from the Intensive Care National Audit and Research Centre (ICNARC) showed that the trust had a higher level of delayed and out of hours discharges from the critical care unit to other units of similar size. We also saw that one person stayed on the short-stay ward for 24 hours and another person stayed for 48 hours which was outside the recommended length of stay of 12 hours. While the bed occupancy was monitored and the trust worked to proactively manage the situation through multidisciplinary meetings at times the trust was forced to be responsive and flexible due to the demand being placed on it. At these times patients could be moved at night and or placed in areas not designed or equipped for patients care such as window bays. While we were told that there was a criterion to follow to identify the most suitable patients to be cared in these areas and that they should be independent, staff told us that this was not always the case. Staff also told us that when the number of patients in the ward increased through use of additional beds staffing levels were not adjusted to reflect the difference.

The trust told that one of their challenges was the number of inappropriate attendance in A&E. The trust had generally

Are services responsive to people's needs?

(for example, to feedback?)

performed lower than the national average for A&E waiting times. However, in relation to meeting the 95% A&E four-hour waiting target, it had performed better at some points and lower at others. The trust consistently performed better than the national average for the percentage of admissions via A&E waiting 4 to 12 hours from the decision to admit until being admitted.

Discharge

In response to an identified need to more effectively manage patient discharges, the trust had introduced an integrated discharge team, and there were plans to expand the team. The team was working with all areas of the trust to ensure timely, effective and safe discharges. The integrated discharge team worked with social services and the local community to ensure early engagement with discharge plans. The trust had worked with others to improve the transport service and would ensure that additional transport services were available when required. In response to demand, the trust had opened additional beds at a nearby location where patients who no longer required acute care could continue to receive support until ready for discharge. There was also a hospital at home team, and a surgery bridging team to support patients at home. All of the initiatives were working to assist the trust in managing their bed occupancy level and ensuring safe and effective discharges.

The palliative care team managed rapid discharges for people who wanted to return home to die. They had close links to community services to enable care packages to be set up at short notice to enable people to return home if this was their wish.

Mixed sex accommodation

In the Adult Inpatient Survey 2012 the trust was worse than other trusts for the 'Hospital and Ward' area. One of the areas where the trust score was worse than expected related to mixed sex sleeping areas and the use of shared bathroom facilities. We observed that the Medical Assessment Unit was a mixed sex ward with shared bathroom facilities. The Intensive Therapy Unit (ITU) would be expected to be a mixed sex ward during the time patients required intensive care, but people's privacy and dignity were being affected by the length of time they had to wait to be transferred to a ward when they no longer needed to be on the unit. The trust told us that the use of mixed sex accommodation was monitored and reported.

When we checked the national figures we found that the trust had reported 11 breaches in January 2013 and six in February 2013 and none since. This was not reflective of what we saw or were told by staff.

The lack of bathroom facilities on the ITU unit was also an issue, as patients had to go to the next ward for these. In addition we observed poor practice relating to privacy and dignity in the operating theatres. The area where patients were received into the department prior to their operation was open and more than one patient could be in this area at any one time.

In some areas people's right to confidentiality was affected by personal information being on display in open areas and confidential discussions were witnessed taking place in open areas where they could be overheard.

Complaints

There was a Patient Advice and Liaison Service (PALS) that offered a confidential service for people who needed information, help or wanted to comment about any aspect of the services provided at the hospital. The PALS office was clearly accessible in the main hospital reception area. Information about the service was also displayed throughout the hospital.

Local stakeholders had raised concerns about the trust's complaints system and we found that the trust's complaints management system was under review. This had occurred in recognition of the fact that it did not always manage complaints effectively and efficiently. Internally the trust had acknowledged that changes to how complaints were managed in the maternity unit had had a positive impact and they were working to ensure that this good practice was shared across the trust. We were told that delays were caused by the number of times the information was reviewed by different people and the need to chase people for responses. The plan is to streamline the process, with directorates taking more control and being responsible for the lead investigator with support from the complaints department.

We were told that both matrons and consultants engaged in local resolutions and would meet with patients and or their families. Staff from the complaints team told us that there was good communication with the matrons and nursing sisters and, where necessary, weekly catch-up

Are services responsive to people's needs?

(for example, to feedback?)

meetings took place. The trust monitored complaints through the monthly quality and safety committee meetings. The directorate holds the responsibility for action plans and the monitoring of their implementation.

We saw that information on the trust's website was available in multiple languages. Staff told us of times when patients with hearing impairment had been supported using a telephone texting facility. We were also told of times when language barriers and other communication limitations had been managed; these included the use of

an interpreter. Staff who spoke more than one language were also encouraged to speak to patients in their native language. The trust had a multi-faith room which was available for use by both patients and staff. We found that all areas of the hospital we visited were accessible.

Consenting

We were concerned that not all patients appeared to have been consented prior to their transfer to the theatre area. This is not considered best practice.

Are services well-led?

Good 

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Summary of findings

The trust faced challenges following the recent collapse of the merger plans, and it had not yet developed an alternative vision for the organisation. There were a number of examples of good practice and examples of shared learning in the organisation. However, in some cases changes in practice in response to learning from serious incidents took up to 12 months to implement. Although senior staff felt that there was an emerging vision, this had not yet been formally agreed. There was said to be a strong executive team that was visible throughout the trust which was supported by staff. The executive team had a clear understanding of the key risks in the organisation, particularly the current situation in A&E and the trust's occupancy levels. The trust had implemented a number of actions, but there had not been any clear measurable improvements. There were no clear timelines with projected outcomes and impacts.

Our findings

There had been plans for the trust to merge with another local trust in order to become a foundation trust. These plans had been stopped in the summer and as a result the trust was reconsidering its position. Although senior members of staff felt that there was an emerging vision, it had not been formally agreed. Some members of the executive team were interim appointments, though the Chair said that there was a strong executive team. A directorate level development programme had just been started. The organisation had a relative flat management structure with a direct connection between the Clinical Directors and the Chief Executive Officer (CEO).

Throughout the trust staff told us that the trust's leaders were visible and approachable. The Director of Nursing took part in walk rounds with the matrons on a weekly basis and both the Chair and the Non-Executive Directors (NEDs) participated in walk rounds on wards, talking to staff and patients. We were told that the NEDs had been buddied up with clinical areas and these were the areas they were expected to visit, though there was no formal learning from these visits.

We saw that there was clear engagement between the executive team, the site team and bed management. The Chief Operating Officer took part in the bed management meetings and the CEO and the Director of Nursing visited the site team office first thing in the day. There was open discussion and debate about the occupancy levels and how to manage the demand. While this occurred on an ongoing basis and decisions were made, the trust's actions had not yet fully embedded, and it was not possible to assess their long term impact.

There was evidence of good leadership across the trust with action being taken at local and executive level. The executive team had a clear understanding of the key risks in the organisation, particularly the current situation in A&E and the trust's occupancy levels. It is acknowledged that the trust had implemented a number of actions which include opening intermediate care beds on another site and planning to rebuild the waiting and assessment areas of the A&E Department to meet increasing demand. However, there were no clear timelines with projected outcomes and impacts.

It was clear from talking to staff and information provided by the trust that there had been a refocus on patient experience and quality.

There was an established governance system in place which included audits, accidents and incidence and complaints. Each directorate had its own governance meetings which then fed into trust level reporting. Some staff said they were not informed of the outcomes of audits or the incident reports. There was no formal system for monitoring action plans that had been created in response to complaints. We were concerned about the length of time it had taken to investigate some serious incidents and the time to implement changes to practice in response to learning. There were risk registers at directorate level and at trust level. Where risk had been identified, actions had been agreed, taken and were being monitored.

Learning and development

Junior doctors told us that the consultants were supportive and visible, though they did raise concerns about medical cover and support out of hours in both surgery and obstetrics and gynaecology. Doctors in the A&E department told us that the use of a large number of middle grade doctors meant that they did not always feel supported in their role. The medical education team was described as "the best I have ever known in a city hospital".

Are services well-led?






Good 

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Through consultation with staff, a Nursing Assistants (NA) and Healthcare Support Workers code of conduct had been

introduced. The project was undertaken with input from the NAs to ensure that this was reflective of their belief in the standards required to deliver safe, quality care and an acceptable overall patient experience.

Accident and emergency

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

Information about the service

The Accident and Emergency (A&E) department provides 24-hour, services seven days a week. It has an attendance rate of approximately 100,000 patients a year. The department has a triage room (used to carry out initial assessment of adult patients who walked into the department) adjacent to a main reception and a waiting area and a minors area (for less serious injuries). It also has a triage cubicle (used to carry out initial assessment of adult patients who arrived in the department by ambulance) adjacent to a majors area (for more serious injuries and illnesses) and a resuscitation room containing a dedicated area for children. There was a separate children's area within the department that contained its own triage room (used to carry out initial assessment of children who arrived in the department), waiting area and treatment cubicles. Within the majors area there was also a room dedicated to the needs of patients requiring psychiatric care and a room dedicated to the needs of patients requiring obstetric or gynaecological care.

There was a short stay unit adjacent to the A&E department. This unit was managed and staffed by the medical unit. Adult A&E patients requiring observation and/or treatments of short duration (up to 12 hours) were cared for here before being reviewed and either discharged home or admitted to the hospital.

We visited the A&E department and the short stay area during the day on 5 and 6 December and in the evening/night of 9 December 2013.

We spoke to 17 patients during the inspection, as well as doctors, nurses, radiographers, managers, administration

staff, nursing assistants, paramedics, other ambulance staff and housekeeping staff. We talked to patients and staff about care, treatment and facilities and we also observed care being provided. We reviewed records during our visit.

Accident and emergency

Summary of findings

We found that A&E had the potential to be unsafe as there were insufficient numbers of appropriately skilled staff to deliver care. This was because there were not enough nurses qualified in the care of children and the medical staff team was not staffed to the agreed capacity and skill mix. The triage system in the minors area led to some patients' needs not being assessed a timely manner as it was not clear that patients were required to wait to attend triage in one area and then book in and wait in another area. Staff were not always able to access current national and best practice guidelines to deliver safe effective care. Staff were caring and responsive about patients' needs but did not always maintain patient privacy. We observed examples of good individual leadership at department level but there was evidence that ongoing safety issues, for example insufficient substantive staffing, had not been resolved at a higher level.

Are accident and emergency services safe?

Requires improvement 

Staffing

There were insufficient numbers of appropriately skilled staff in the department, and vacancies were filled with locum and agency staff. We were told that the department had an establishment of six consultants and 12 middle grade doctors but currently employed four consultants and four middle grade doctors. This was confirmed by records we saw. There was a consultant on duty in the department between 8am and 10pm, and outside of those hours a consultant could be contacted by telephone. We were told that the four consultants were working additional hours to cover one of the vacant consultant posts. Records confirmed that the eight vacant middle grade doctors' shifts were being filled by locum doctors. Junior doctors told us the use of a large number of locums was impacting on the support they received. They were positive about the support they received from the consultants. Medical staffing had the potential to place people at risk.

Initial assessment (triage)

We found that for adults who walked into the department information on the adult triage process was not clear. Staff told us that adults who walked into the department waited to be triaged on designated seats outside the triage room. Once triaged adults were directed to reception staff to be booked into the department and then directed to the area allocated by the triage nurse to await further assessment. There was limited signage in place to inform adults of the required process. There was one A4-sized paper sign taped to the wall opposite the main entrance to the department and A4-sized paper signs taped to the chairs next to the triage room instructing adult patients to wait there to be triaged. We spoke with one patient who told us they had not noticed the signs when they arrived and had been sitting in the general waiting area for 45 minutes before they realised they needed to go to the triage area. Another patient told us that they had not noticed the signs and had tried to book in with the reception staff who had told them to "go sit in the triage area". This patient told us they then sat in the general waiting area as it "wasn't clear" where the triage area was. They told us that it wasn't until they noticed the A4-sized paper signs taped to the triage area

Accident and emergency

chairs that they moved to the correct area. This meant that for both patients the assessment of their condition and prioritisation of their treatment was delayed which had the potential to cause harm.

Patient's records

During our visits we looked at ten adult patients' records. We saw that staff were following the hospital policy of using a scoring system to identify adult patients at risk of deterioration (called PAR scoring). Staff told us that the policy was available to them on the hospital intranet. We saw that staff followed the action stipulated in the policy in response to the PAR scores calculated. This activity meant that adult patients at risk of deterioration were identified early and were able to receive timely treatment to promote their recovery.

Hand washing

In the 2012 staff survey only 52% of staff said hand washing materials are always available. With the exception of the male staff toilet, all toilets in the A&E department were stocked with soap and paper towels. When we told staff that one soap dispenser was empty, they refilled it while we were present.

Patients told us that they had witnessed staff washing their hands after seeing patients in the department. However, we saw one member of staff have contact with four patients consecutively without washing their hands at all. This had the potential to place patients at risk of infection.

Security

On all days we visited the hospital we saw that hospital security staff were present and based in an office located adjacent to the A&E main reception. Staff told us that they were able to summon security assistance "instantly" 24 hours a day via the hospital's telephone bleep messaging system.

Escorts

Staff told us that patients transferred to other parts of the hospital including wards were accompanied by a nurse or healthcare assistant. We observed that patient safety was maintained during transfer in the hospital because a trained member of staff accompanied them.

Pressure area care

Our intelligent monitoring system indicated that incidents of pressure ulcer development in the hospital were above national averages. We observed that assessments of

patients' skin integrity began in the A&E department. This demonstrated that patients' risk of developing pressure ulcers was being assessed before admission to the hospital.

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate 

Psychiatric services

We saw that there was a system in place to ensure patients (adults and children) could be referred to psychiatric services 24 hours each day. However, staff told us that patients referred to psychiatric services sometimes endured a wait of several hours before a member of the psychiatric services teams attended the department to assess them. We saw that one adult patient waited two hours between being referred to the psychiatric service and a member of the psychiatric services team arriving in the department to assess their needs.

Hospital at night team

There was an effective system in place for patients to be seen directly by other teams of doctors when the emergency department was busy. Staff told us that it was possible to ask other teams of doctors to see a patient directly without the need for the patient to first be seen by an A&E doctor. For example, it was possible for A&E staff to ask the orthopaedic doctors to see a patient with a broken bone directly in A&E.

Ambulance liaison officer

Integrated working with the ambulance service was coordinated in the department by an ambulance liaison officer. We saw them coordinate the emergency transfer by ambulance of a patient to another hospital. This expedited the patient's safe transfer and released A&E staff to carry out other patient care duties. We were told that they also received patients arriving by ambulance when the wait to be triaged is greater than 15 minutes. This released the ambulance crew within the 15 minute handover target and ensured that patients were not left unattended while waiting to be triaged.

Accident and emergency

Pain management

The assessment and management of adult patients' pain was consistent. We looked at three records and saw that a pain score was recorded for each patient on arrival in the department. The records demonstrated that analgesia was given in a timely manner (within 60 minutes of arrival). We also saw that each patient's pain level was reassessed after analgesia was given and another pain score recorded. This meant that adult patients' pain was assessed, managed and recorded effectively.

National and best practice guidelines

Staff were not always able to access current national and good practice guidelines to deliver safe care. On 5 December 2013 we looked at wall-mounted documents and a ring binder that contained out-of-date and incorrect national and good practice guidance on patient care. For example, we saw guidance on the management ketoacidosis dated 2009 this has been superseded by guidance published in 2011. When we mentioned this to staff they told us that there was not currently a system in place to ensure that all national and good practice guidance on patient care was updated with current guidelines. During our visit on 6 December 2013 we saw that this information had been removed from the department. We asked staff how they were able to access national and good practice guidance on patient care now that the information we had seen had been removed. Staff we spoke with were unaware that the information had been removed and were unable to show us how they now accessed national and best practice guidance.

Are accident and emergency services caring?

Good 

Patients told us that they felt cared for in the A&E department and that they had been offered food and drink. A carer told us that they had used the A&E services many times and that this was "a lovely hospital".

We saw that staff were accessible to patients and their carers and that they approached them in a calm and kind manner and took the time to talk to them and explain what they were doing.

Communication

We saw that staff kept individual patients in the resuscitation area and majors informed about their plan of care and treatment. For example, we saw one nurse inform a patient and their relatives of the planned time of a specific test being carried out by another department.

We saw that patients in all other areas of the A&E department were kept informed of the waiting time to see a doctor by regular announcements over the public address system. These announcements also gave information on alternative sources of consultation should patients not want to wait longer in the department as well as information on the system of prioritising patient care in the department. Our visit lasted seven hours on the evening of 9 December 2013 and we heard five such announcements during this period of time.

Food and hydration

We saw that staff offered beverages to patients who were able to drink. There was a small kitchen adjacent to the majors area that contained food and drink available for staff to give to patients when required. This meant that patients' dietary needs could be met at any time.

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

Requires improvement 

Waiting times

The trust told that one of their challenges was the number of inappropriate attendance in A&E. The trust had generally performed lower than the national average for A&E waiting times. However, in relation to meeting the 95% A&E four-hour waiting target, it had performed better at some points and lower at others. The trust consistently performed better than the national average for the percentage of admissions via A&E waiting 4 to 12 hours from the decision to admit until being admitted.

The computerised booking-in system tracked patients' waiting times. We saw that during our visit on the 9 December 2013 the waiting time more than doubled in a

Accident and emergency

four-hour period (from 1 hour 11 minutes to 2 hours 46 minutes). Staff told us that this was due to there being five patients in the resuscitation room which was impacting on the availability of staff to see other patients.

Staff told us that in response to the needs of patients living with dementia volunteers called 'dementia buddies' had been introduced in the hospital. Staff told us that they were able to call on the dementia buddies to stay with patients living with dementia in order to complement their nursing care and meet more of their individual needs. The introduction of dementia buddies was appreciated by staff, although was a limited service that only operated during the day until 3pm.

We observed board rounds where doctors reviewed patients' assessments and treatment plans. We observed that the most senior A&E doctor on duty led these board rounds, where advice was given to other staff to help streamline and prioritise patient care in the whole department. We saw that when certain areas of the department became busy, staff were redeployed in order to meet the needs of the patients there. For example, following a board round one middle grade doctor was redeployed from the majors area to the children's area to meet the increased needs there. However, staff told us that this practice did not take place for patients with minor injuries, as patients with more serious conditions could not be left by staff.

The department took proactive action at times in response to patient needs. For example, staff told us there was a contingency to have two nurses in the triage room for adults who walked into the department at very busy times. However, we were told that it was difficult to maintain patient's privacy when two nurses were working together in one room with only a screen between them.

Short stay area

We saw that all patients in the short stay unit were cared for on a hospital bed and had their own bedside locker. We saw that patients of the opposite sex were cared for together in the same area and that the two toilet facilities were being used by patients of both sexes. However, we saw that there were separate toilets for men and women in the A&E department. During our visit on 5 December 2013 we saw that one patient had been in the short-stay unit for 24 hours and another patient for 48 hours. This meant that patients were being cared for in an inappropriate environment for their needs.

Staff told us that in response to incidents where patients' jewellery went missing while they were in the department a flow chart on the recording and management of patients' jewellery had been introduced. Staff showed us the flow chart and told us that since it had started being used there had been no further incidents.

Patient privacy

We saw that patients' privacy was not always maintained as triage in the adult area of the department could be overheard. These interviews included the sharing of personal confidential information. Similarly we observed that handovers and other discussions between hospital staff at the nurses' stations could be overheard. These discussions included treatment plans as well as personal information. This meant that patient confidentiality and privacy was compromised.

We saw that patient details displayed on computer screens throughout the department were left unattended at times and were visible to patients and visitors. Staff told us that screens left unattended by staff automatically reverted to screen savers after a short time, protecting patient privacy. We observed six unattended computer screens around the department and saw that only one was displaying a screen saver. The remaining five computer screens displayed patient details that were visible to others.

In the minors area we saw that patient details (which included a list of the investigations they required) were stored in a ring binder. This ring binder was left open on the nurses' station. Staff told us that it was used by the triage nurse to communicate the investigation requirements of patients to staff working in the area. The binder was visible to patients and visitors.

Are accident and emergency services well-led?

Requires improvement 

We saw good individual leadership of medical and nursing staff at department level. However, there was evidence that the ongoing safety issues, for example staffing levels, had not been resolved in a timely manner at management level.

Accident and emergency

Staffing

A nurse consultant started work in the department at the beginning of the week of our visit. Staff told us that the purpose of the nurse consultant was to improve leadership in the department as well as to streamline admission and ambulatory pathways.

Plans were in progress to recruit and retain additional doctors and nurses to the department. We were told that clinical and leadership training and other professional development opportunities for the middle grade doctors were being created to support recruitment, retention and career progression. Two substantive middle grade doctors had already been put forward as candidates for a new Emergency Medicine deanery-led programme. However, we spoke with nine staff (including locum and agency staff) who told us that they were not aware of leadership training or other developmental opportunities in the department.

Staff training

Records showed that the uptake of bi-annual mandatory update was lower than projected by the hospital. The trust's training on managing risk was showing green with an attendance of 85.6%. The other mandatory training, which included moving and handling, conflict resolution and information governance, were showing as amber for

the A&E department. They were above 73% but below 85%. Staff were unable to demonstrate how this shortfall was being resolved. This meant that patients may not always be cared for by staff adequately trained to do so.






Supervision

We were told that hourly board rounds had been introduced recently with the purpose of streamlining and prioritising patient care in the A&E department. Their purpose was to also provide the opportunity for consultants or senior middle grade doctors to support others in clinical practice. Our visit lasted seven hours on the evening of 9 December 2013 and we saw that there were only two "board rounds" during this period of time (one at 7.25pm and the other at 8.25pm). Staff welcomed the supervision offered by the "board rounds" but told us that "we still need more supervision".

Communication

Senior management communication with A&E department staff was not always effective. Whilst there was a newsletter available to staff in the A&E department we saw that the information it contained was not always clear. For example, delivery of 95% was listed under achievements and risks but did not indicate what achievement or risk it related to. Staff told us that they did not always receive feedback when they raised issues with senior management.

Medical care (including older people's care)

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

Information about the service

Wards within the medical directorate provide general and specialist medical care to patients. Services include care of people who have had a stroke, people with respiratory illnesses, people with diabetes and frail older people.

We made both announced and unannounced visits as part of our inspection of these wards. We visited Beech, Clinical Decision Unit, Ebony, Laurel, Linden, Palm and Oak Wards and during the unannounced visit we went to Spruce ward (stroke unit). We also revisited Palm and Chestnut wards.

We spoke with 32 patients, relatives and friends. We also spoke with 57 staff including registered nurses, the outreach team, nursing assistants, ward managers, doctors, consultants, physiotherapists, pharmacist, porters and ward clerks. We looked at 23 patient care records during our visit to the acute medical wards.

Summary of findings

Overall, the standard of care and treatment in medical care was good. Teams were well led and supported by leaders at all levels in the service. Staff were listened to and had access to specialist training. There was positive feedback from the patients, relatives and visitors who we spoke with. They described caring and responsive staff who met their treatment needs. On a number of wards changes had been introduced in October 2013. These included increased staffing numbers. During our visit we could see that improvements were taking place. However, there had been insufficient time for many changes to have become embedded. This meant that the trust was still improving against current performance indicators. Patient records were generally up to date with full details available to ensure that staff could provide safe and consistent care. The use of window bays, witnessed during the unannounced visit, showed that there was pressure on the hospital to cope with the level of demand. Staff were concerned about the use of 'window bay beds' and the potential impact on quality and safety.

Medical care (including older people's care)

Are medical care services safe?

Good 

Safe practice on the wards

We observed that there was adequate hand washing facilities and gel dispensers available on all of the wards we visited. We saw that staff used these facilities in appropriate ways. This ensured that patients were protected from cross-contamination. We also saw that personal protective equipment (such as gloves and aprons) was available to staff. On Beech ward we observed that barrier nursing (treating infection patients in isolation) had been put in place. Signs were in place alerting staff and visitors to the procedure to be followed. We saw staff following safe practices that protected patients needing barrier nursing as well as other patients on the ward.

All the wards we visited were clean. However, two bathrooms on one ward had soiled shower curtains and a chair in the shower room had been damaged. These items posed a potential risk of infection and were highlighted to the ward manager, who reported them immediately.

We attended a meeting that discussed the outbreak of norovirus on Spruce ward (the stroke unit). Staff discussed how new cases were being monitored and the arrangements in place to care for patients with the infection. A risk assessment had been put in place to manage the safe staffing of the unit and minimise the spread of the infection by restricting staff to work on that ward only during the outbreak. We saw that there was a forward plan and contingency arrangements for the safe management of newly admitted patients who could not access the stroke unit. There were daily review meetings in place. These arrangements ensured the safety and welfare of patients on the stroke unit and elsewhere in the hospital.

Staff we spoke with on Beech and Palm wards were unaware of the Mental Capacity Act requirements or the impact of the Deprivation of Liberty Safeguards. We did review this with the safeguarding lead for the trust, who confirmed that training had been provided for staff up until June 2013 and that new training was being devised for 2014. The staff we spoke with told us they had not received any training. Medical staff had received training and we saw two samples of people's mental capacity being assessed

and best interest meetings conducted. There was a potential for patients to be at risk because some staff did not know how to fully assess patients' capacity to make decisions for themselves.

We observed medicine administration rounds on three of the wards we visited. We saw on one ward that a member of staff was wearing a red tabard to indicate that they were carrying out the medication round. The red tabard advised people not to disturb the member of staff because of the medication activity. On Laurel ward, the lack of a treatment room meant that medicines were prepared behind the central ward station. We saw that staff were interrupted whilst drawing up medicines, raising the risk of incorrect preparation. One member of staff we spoke with told us, "Sometimes we are interrupted ... not when we are preparing controlled drugs, they leave us alone then." Interruptions meant there was the potential to place patients at risk.

Staffing

We reviewed workforce information provided by the trust and noted that there were 65 full-time vacancies in the acute medical directorate. This included senior medical posts as well as nursing and nursing assistant grades. We were told by staff that staffing skill mix reviews had been carried out on a number of wards. We were shown records that detailed business cases for additional staff being approved by the trust. This demonstrated that the trust was committed to ensuring that staffing levels were safe. One report we saw showed that there were 116 candidates in the recruitment process. This showed that work was underway to fill vacancies. We talked with staff about the impact of these staffing levels. They told us that they had access to bank staff and to agency staff when needed.

Junior doctors told us that the medical handover was good, with the handover round at 9am highlighting sick patients and the priorities. The medical education team was also praised.

Medical care (including older people's care)

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

Good 

Discharge Arrangements

We looked at the process in place to support patients returning home once their condition had improved. We were told about the integrated discharge team that attended ward rounds and handover meetings. There was positive feedback about the support they provided in planning discharges in an effective and safe way. We were also told about the discharge summary forms that had been introduced to ensure that the right things were in place for when the patient was ready for discharge. Staff told us that having Social Services on site in the hospital had helped to improve the process for supporting patients who needed to move into residential or nursing care.

We went to the medical care discharge lounge situated on one of the wards and found that an effective process was in place to ensure that beds were being made available for patients with acute needs whilst those ready for discharge were supervised by staff in an area awaiting transport home. This was a dedicated area in addition to the hospital's discharge lounge. Staff told us they were monitoring the effectiveness of the discharge lounge to demonstrate its value in contributing to the bed capacity problems in the trust. One ward manager told us about the effectiveness of the bed meeting. They had been cautious about the effectiveness of having to attend another meeting; however, they reported that having the right people in the room to manage the discharge process had helped to unblock the process.

Caring for people with dementia

We found there was a positive approach to managing the needs of people with dementia. We saw records that showed that patients over the age of 75 were routinely screened for dementia so that appropriate care processes could be put in place to support their needs. Environmental changes had been made to be sensitive to the needs of people with dementia. For example, we saw that bays on the Ebony ward had been colour coded, and toilet seats had been introduced that were a different colour to the toilet pan. We saw that people with dementia had a blue wrist band so that staff could easily but

discreetly identify a patient with the condition. We looked at care records and found that patients with dementia all had a 'This is me' document in place so that staff understood the patient's history and background. The trust had also introduced a team of 'dementia buddies'. Staff told this scheme had been very successful. Buddies were introduced to people with dementia and they would sit with them and read with them or support them in an activity. There were plans to extend the scheme so that all areas in the trust could access a buddy for people with dementia when needed.

Audits of the care provided

We found there was an active programme of audits in medical care. We looked at the audit that had been carried out in response to the higher than average mortality rate for stroke patients at this trust. We found that a systematic review of cases, including an independent comparison, had been carried out. The audit identified that there had been a poor prognosis at the outset of the patients' treatment. The audit showed the specialist support that had been provided to patients with complex conditions. It also identified that two patients had not died as a result of their stroke but other health problems that were present. The audit showed an analysis had been carried out to ensure that the right processes were in place to support stroke patients.

There were audits of catheter care and falls. There were changes introduced from these audits. These included placing high risk patients in beds that were visible and providing one-to-one nursing care at night when a person was most prone to falls. We observed one doctor contacting a family to explain their relative had fallen in the night. The ward manager and matron had already started an investigation into the incident. This showed that the medical care team were taking action on high-risk activities to ensure the safety and wellbeing of patients.

Medical care (including older people's care)

Are medical care services caring?

Good 

Patient feedback

All the patients, relatives and visitors we spoke with said they were satisfied with the care and treatment they received. Comments included: "My doctor is really good ... the nurses are very attentive" and "I can't praise the staff enough".

Patient treatment

We observed that staff treated patients with dignity and respect. We observed staff saying, "Knock, knock," and awaiting permission to enter when curtains were drawn around a patient.

Staff demonstrated kindness, skill and empathy. One nurse told us, "We can't help getting attached to patients; it's so difficult when they deteriorate." This nurse went on to explain the steps taken to support patients who declined and the additional support that could be provided. We observed one consultant on the Spruce ward demonstrate an inclusive approach to reviewing a patient's care with them and the junior doctor.

We observed two physiotherapists supporting and encouraging a patient to develop confidence in walking. They went at a pace the patient was able to manage. They were praising achievements and ensuring the safety of the person during the activity. Care records we reviewed included complete information about the patient's history. We saw that individual risk assessments were in place and there were daily evaluation records showing the patient's progress and improvement.

We looked at 19 care records and they all showed evidence of consent. For example, one patient's record showed that they had agreed to support for mealtimes. We saw that a red tray system was in place to indicate that a patient required assistance with their meals. However, during our 40 minute observation we did not see any member of staff helping the patient. We reviewed this patient's food and fluid intake charts and saw that despite a pressure ulcer care plan being in place for three days it was documented that the patient had had less than 380mls of fluid each day. Individual patients may be at risk of increased pressure ulcers when insufficient fluids are available.

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

Requires improvement 

Learning when things go wrong

Staff described many examples of improvements they had introduced to their practice following feedback from patients and in response to incidents that had happened. For example, on Ebony ward a patient complaint about food had led to a review of the variety of food available on the ward. A nutritional study day had been set up for staff to attend and a 'taste' session had been set up with the catering team so that staff could experience the food they were providing to their patients. This included tasting the food thickeners and understanding what this texture was like for patients. Staff told us this had increased their awareness about offering alternative food choices to patients.

We saw that in response to the above average rates of catheter and UTI infections, a catheter care pathway had been introduced. A checklist had been introduced to ensure the right checks were carried out and dated. Staff we spoke with were aware of the steps to take to reduce the risks of infection through effective catheter care.

We saw that one ward had responded to a complaint about a late discharge caused by lack of transport by introducing a contingency process to ensure that people were given support to get home at a reasonable time of day.

Admission of patients to appropriate wards

We looked at the number of patients who were not being treated on the medical ward deemed as most appropriate for their care. We found that three patients were on alternative wards following admission with a stroke (Beech and the Clinical Decision Unit). These patients had not been admitted to the Spruce ward the stroke unit due to an outbreak of norovirus which had resulted in the ward being closed to new admissions. We looked at exception reports for August and September 2013, which showed the previous occasions when patients requiring specialist stroke support had not been admitted to Spruce. For example, in September six patients had been admitted to the Clinical Decision Unit and three to the medical short

Medical care (including older people's care)

stay unit. These records also showed that out of hours and at weekends there was a delay in the time patients waited to be seen by the stroke nurse which may have an impact on the outcome. This was confirmed by the outreach team and the senior staff from the stroke team. The records that we reviewed showed that specialist support had been provided to patients who were not on specialist wards. This ensured that staff with the appropriate training were caring for patients when needed.

On the 13 December 2013 we visited Spruce ward, as the ward had reopened following the norovirus outbreak. We found that the ward had been deep cleaned to reduce the risk of further infection. We were able to review the process that patients with a stroke or a suspected stroke followed. We were told that when a patient with a stroke was expected the ward team were alerted by the ambulance service and the emergency department. Upon arrival at the hospital patients were seen by the stroke team and started on the stroke pathway of care. The ward planned to retain one bed free on the unit so that access for new patients could be provided promptly. When this was not possible, patients were supported on other wards by the stroke team. We observed that the ward was busy yet calm. We looked at four care plans. There was evidence of family and multidisciplinary team working for the benefit of the patients.

We talked to the outreach team about the management of patients not on a specialised unit. They told us that patients were reviewed by an outreach nurse to ensure their needs were being met. Any concerns would be raised as an incident on the ward and followed up by the ward manager and matron to make improvements. The outreach team carried out audits to ensure that improvements took place. For example, an audit of patients' fluid charts had been carried out. Five wards had been part in the audit; a need to improve the practice of fluid recording had been identified. An action plan had been put into place and included improved record keeping targets, providing skills training for staff, updating staff on the requirements of the policy and spot checks by the nurse in charge for ongoing monitoring. This demonstrated that arrangements were in place to monitor patients' needs and action taken when standards set by the trust had not been met.

We observed that patients' confidentiality was compromised on some wards. We also observed phone

calls about confidential matters being made on Palm ward within listening distance of other patients and people on the ward. During the unannounced visit we observed doctors discussing patients with other staff in areas where they could be overheard by people close by.

Staff told us about the use of 'window bay beds'. They described the practice of installing an additional bed in the window area of wards when all other beds had been filled. Some staff told us that wherever possible patients occupying the window bay bed would be a patient being discharged the following morning. However, other staff informed us that patients with more acute nursing needs were placed in the window bay bed. Placing people in window bay beds put them at risk of being treated in an inappropriate environment as these areas were designed or equipped to be used for this purpose. People's privacy, dignity and safety were compromised by the lack of facilities available to them.

We found that there were mixed gender bays on the Clinical Decision Unit and on Chestnut ward (cardiac care). One member of staff told us they discussed mixed bays with patients before admitting them to the area. When patients improved, or when a bed became available in a single gender bay, patients would be moved. Staff told us in this way patients received the specialist treatment they needed more promptly. The Medical Assessment Unit was found to be a mixed sex ward.

Are medical care services well-led?

Good 

Listening to staff

We found that overall medical care was well led. Staff told us that they liked working on the wards. They told us they felt supported by managers and clinical staff. They also said that senior managers, such as the Chief Executive and Director of Nursing, visited their wards and listened to their views.

Staff said there was supportive teamwork on the wards, and they felt they could depend upon their colleagues. They told us that they felt that concerns about staffing levels had been listened to and numbers of staff had been increased. One ward manager told us that extra staff had

Medical care (including older people's care)

been requested and approved: "They trust my judgement." We saw that a risk assessment had been put in place and the rotas demonstrated that the extra staff had been provided.

A number of wards we visited had recently reviewed their skill mix. We saw there were arrangements in place to recruit staff to the ward. One rota we looked at showed an increase in the staffing numbers being covered by bank and agency staff to reflect that additional staff were required immediately. A recruitment plan was also in place.

We observed the morning bed meeting and found that staff took a proactive approach to the problems anticipated by the changing status of bed availability in the hospital. There were monitoring processes in place to identify where beds






were available or were likely to be. There was active liaison with allied health professionals, and ambulance and social services to support timely and appropriate discharge arrangements.

Staff training and development

We saw there were processes in place for the regular review of staff performance. Staff told us they received feedback and felt supported by their line manager. Staff were provided with training identified as part of their appraisal and to ensure skills and knowledge was kept up to date. One member of staff said, "Our ward manager is very good and on the ball; we have appraisals, regular study days and meetings every four to five months."

We saw records that showed that mandatory training, induction and appraisal were monitored and improved.

Surgery

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

Information about the service

Surgical services provided by the trust include inpatient surgical wards, a day surgery, a surgical assessment unit and theatres. The Surgical Department at Darent Valley Hospital offers a full range of assessment, treatment and follow-up for a wide range of surgical procedures. At Queen Mary's Hospital and Erith and District Hospital the trust offers an outpatient and elective day surgery service. This inspection focused on the services at Darent Valley Hospital.

The hospital provides a range of surgery including, general surgery, trauma and orthopaedics, urology and gynaecology.

We visited:

- Theatres
- Two general surgical wards (Rowan and Juniper), one of which included a surgical assessment unit
- An orthopaedic ward (Maple)
- A gynaecology ward (Mulberry)
- A urology ward (Redwood)

We also visited the day surgery ward and surgical admissions lounge.

We observed care and treatment and spoke with staff, patients and visitors. We tracked a patient from admission for planned surgery and followed this patient's progress through until they returned to the ward after surgery.

Summary of findings

Patients received safe and effective surgical care. We saw that some wards worked with fewer staff than needed. However, the trust was aware of this and recruitment had taken place. A number of staff were due to commence employment in the new year. There was a multidisciplinary approach to providing effective patient care.

Staff we observed were caring. However, patients' privacy and dignity were not always maintained in theatres, and we were concerned with some of the practice observed around patient consent. Staff responded appropriately to changes in patients' care and treatment. Staff told us how they responded to the increased workload when admission numbers increased, particularly when extra beds were placed on the ward. However, actions the trust was taking to respond to fluctuating demands of the organisation did not prevent these situations reoccurring. Staff told us they worked in a well-led organisation. They told us the culture was open and transparent, and there was a clear willingness by all staff to learn.

Surgery

Are surgery services safe?

Good



Staffing

Nursing staff on all the surgical wards we visited told us that sometimes there was not enough staff to meet the needs of the patients. Staff on one of the orthopaedic wards told us that they had frequently worked with fewer staff than needed. The need for increased staffing on this ward had been acknowledged by the trust as part of the trust nursing skill mix review, which reported to the board in September 2013. We were told that following a recent employment drive ten new staff had been recruited to work on the orthopaedic ward. This included six nursing assistants and four registered nurses. We were told that until these people commenced work the ward was relying on bank or agency staff to cover the shortfall. However, if bank or agency staff were not available the ward would operate with fewer staff than required. On a surgical ward, in response to concerns, the skill mix of nursing staff had been changed to ensure a ward sister was on duty at all times.

Junior doctors raised concerns about surgical cover out of hours, because there had been only one registrar and one more junior doctor on duty. Concerns focused around support if the registrar was in the operating department and the more junior doctor was left to cover the ward and A&E and take calls from GPs. Similar concerns were raised by the obstetrics and gynaecology team.

Infection control

The wards were clean and tidy. There was antibacterial hand gel at the entrance to the wards and instructions for visitors about using it. There were adequate handwashing facilities available on all the wards we visited, and antibacterial hand gel was available on each patient's bed. We saw staff on the ward and in theatres washing their hands and using personal protective equipment such as gloves and aprons appropriately. There was a strict 'bare below the elbows' policy in place and all staff were seen to adhere to this.

Patient safety

We saw there were systems in place to maximise patient safety. This included pathways designed to reduce the risk of patients developing pressure ulcers, catheter related

urinary tract infections and venous thromboembolism (VTE) such as deep vein thrombosis (DVT). Pressure ulcer risk assessments were updated weekly and appropriate care was in place. In addition, all patients who were admitted with a fractured neck of femur were automatically provided with a pressure-relieving air mattress. Staff told us this had reduced the amount of pressure ulcers significantly. VTE risk assessments were undertaken for all patients admitted to the surgical wards. Unless treatment was contraindicated, all patients were given preventative treatment.

Theatre teams used the World Health Organization's surgical safety checklist. This was designed to prevent avoidable mistakes during surgery.

The hospital had a never event in July 2013 relating to a knee implant. Never events are classified as such because they are so serious that they should never happen. The trust had undertaken an investigation and developed an action plan to prevent a recurrence of the incident. Staff that we spoke with told us that learning from serious incidents was fed back to them through managers and ward meetings.

Medical patients were cared for on surgical wards when there was a shortage of beds on the medical wards (these patients are called medical outliers). We looked at how those patients were managed by medical staff to ensure their needs were met in a safe, timely way. Medical staff told us that they conducted what they referred to as a post take round each morning. This ensured that all patients admitted the day before or overnight were reviewed the following day. We were told that there was also a medical outliers doctor who visited the ward each day. This doctor was available for patients who were fit to be discharged, to prescribe their discharge medication and write a discharge summary letter. On a day to day basis the actual practice varied from ward to ward. For example Rowan ward had two medical consultants allocated to the ward. Medical patients were then placed under the care of these consultants. On other surgical wards staff were required to contact appropriate doctors when patients required their treatment to be reviewed, although the medical team visited the ward daily. Staff told us this could on occasions lead to a delay in patients having their treatment reviewed. On the orthopaedic ward, medical patients' care was reviewed by the orthogeriatric team. Staff told us this meant they were able to access doctors in a timely manner.

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We saw the site manager, who had an overview of the hospital's bed occupancy. The site manager told us how they tracked a patient's location and worked to ensure that patients were moved when possible to the most appropriate ward to meet their needs.

We spoke to staff about mental capacity assessments and best interest meetings and saw documented examples of these. Staff told us about a recent deprivation of liberty safeguard that had occurred on the ward. Staff were aware of what processes to take and who to contact if they identified any concerns in relation to patients.

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

Good



The matrons audited information from patients' files, and this was used to inform the NHS safety thermometer, which is a way of measuring harm-free care. Information from these audits was displayed on the wards' quality boards as a way of sharing information with patients and visitors. This informed patients and visitors about the standards of care they should expect to receive from the ward. The boards varied from ward to ward and contained a variety of information that included:

- Important points from reports such as the Keogh Mortality Review Outcome Reports and the Mid Staffordshire Public Inquiry Report.
- The number of patients admitted.
- Lessons learned from complaints.

We saw that initiatives were in place to improve services for patients. These included two-hourly rounds, which were planned, regular checks to ensure patients were getting the care they needed. There were care pathways in place, and these included a colorectal enhanced recovery programme. Theatre staff told us that they were working with ward staff to improve the fractured neck of femur pathway.

We spoke with the emergency access nurse who told us about their role. They were informed when a patient with a surgical problem was admitted to hospital as an emergency via the accident and emergency (A&E) department or a GP. Their role was to ensure the patient

was assessed and received the appropriate diagnostics and treatment as quickly as possible. Patients could be admitted directly to the surgical assessment unit to avoid spending long periods of time awaiting assessment in A&E.

There was a surgical bridging team that supported patients on an enhanced recovery programme when they were discharged from hospital. The surgical bridging team was also able to contact the emergency access nurse if they had concerns about a patient who had been discharged from hospital.

There was an integrated discharge team that supported ward staff to ensure patients were discharged from hospital in a safe and appropriate manner. There were daily meetings with local social services teams to ensure the wider multidisciplinary team was aware of the needs of individual patients.

Are surgery services caring?

Requires improvement



Patients on the wards were cared for in single sex bays. Generally patients told us they were satisfied with their care. They told us doctors and nurses were caring and responsive, and they felt safe in the hospital. We were told "They're [the staff] a great bunch here", "The care is outstanding" and "Staff go out of their way to help me". One person told us, "Most staff are fine but the occasional one is grumpy." We observed that, overall, staff treated patients with kindness and compassion. They spoke to them in a way that they could understand and offered them choices about their care. We saw information within patients' notes which demonstrated that they (or their representative, where appropriate) were involved in decisions about their care. Patients told us that staff were responsive to their needs. We were told, "I only have to ring my bell and they're there."

We saw that patients who required an increased level of observation or care were placed in bays that allowed them to be visible from the nurses' station. On one ward where there were a number of patients who had a dementia type illness, we were told and observed that a member of staff remained in the bay at all times, we saw that this happened. Staff told us they had undertaken training that helped them to care for these patients.

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Meals

We received mixed feedback about meals at the trust. Some people told us they enjoyed the food. One person told us, “The food is excellent, there is enough; they get it just about right.” Another person told us, “It’s not good; it’s like being in the army”. We saw that mealtimes were protected, which meant patients’ mealtimes should not be interrupted. We observed a breakfast and lunch. We saw that patients were offered choices and staff supported them to make their own choices by serving their meals in a particular way. Patients who required support to eat their meals received it appropriately. There was a red tray system in place. This meant that staff were aware of patients who required support to eat their meals. We were told that ward sisters had recently been involved in redeveloping the menus. Staff told us that if they had any concerns about the quality of the food they would discuss this with the kitchen. When patients had missed their meals due to surgery, staff were able to obtain meals for them at any time. Where appropriate, patients were referred and received support from the speech and language therapy team and dieticians. This included when people were having difficulty swallowing or had been losing weight during their time in hospital.

Patients’ records

On admission, patients’ needs had been assessed and care was planned to meet their needs. Patients’ files contained nursing and clinical assessments, risk assessments, care plans and mental capacity assessments, where appropriate. A further file contained the medical details of a patient’s care, any investigations and results and the treatment plan. The records were clear and well-maintained and included evidence of discussions regarding care and involvement of patients and relatives, when appropriate. Some notes were kept at the bedside. These included pressure area checks, mattress settings and where appropriate, nutritional intake and output charts.

We saw completed records of risks of skin damage, falls and infection. Areas of concern had a risk assessment and a plan of care in place. These risks were regularly reviewed. Staff told us care plans and risk assessments were audited weekly for any gaps or omissions, but this information was not recorded. Moving and handling assessments were not reviewed. Staff told us they were aware of this. However,

they made their own assessment each time they attended a patient. One member of staff told us, “We always reassess patients before we move them. Just because someone could mobilise an hour ago doesn’t mean they will now.”

Are surgery services responsive to people’s needs?

(for example, to feedback?)

Requires improvement 

Patient need

We saw that staff on the wards were responsive to changes in patients’ needs and needs of the ward. However, actions the trust was taking to respond to fluctuating demands of the organisation did not prevent these situations reoccurring. We identified this as an area for improvement.

Bed availability

Bed availability was identified at morning meetings. This included patients who were awaiting discharge that day. Patients’ being discharged from the recovery area of theatres were often delayed when beds were not immediately available. This could impact on the rest of the theatre list and create delays. This meant that patients could spend more time that required in the recovery area.

Escalation beds

Due to the high occupancy levels of the hospital, extra beds were sometimes required. These beds were placed in the window area of the bed bays. These were not designated bed areas, and they lacked curtains, call bells, piped oxygen or suction equipment. Staff said they felt that patients were sometimes placed at risk, even though screens were used and patients were provided with a hand bell to call for assistance. They told us staffing levels were not increased to reflect the increase in patient numbers.

Staff told us these beds were generally used for people who were independent and did not require the use of a commode or support with personal hygiene. However, staff were aware there may be an impact for the patient and other patient’s in the bay. Staff told us that if they believed there was an impact this would be reported through the incident reporting system. We saw there had been 11 reported incidents of the use of additional beds on the surgical wards during October and four in November. Concerns listed included compromised patient safety and

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quality of care. One patient was immobile and not suitable for this type of bed. Another patient sustained a fall due to the lack of a light. There were other general concerns related to the impact of safety and quality of care due to staffing levels.

The trust had recently obtained a number of beds in Elm Court. These were available for some patients who met the criteria and were fit for discharge but were awaiting alternative placement. We were told that the use of escalation beds had decreased since these beds had become available. The discharge team had developed good working relationships with local authority social workers and meetings were held daily to discuss discharges. There were a number of 'virtual' beds available at a local nursing home and some rehabilitation beds were available at other locations.

Discharge lounge

There was a discharge lounge available for patients who were ready for discharge and awaiting medication or transport. This had been set up to enable wards to free up beds and ensure that patients awaiting transfer or admission to the ward did not experience unnecessary delays. This was supported by a registered nurse. Space was limited, and the lounge operated from a clinic area where people received treatment such as blood transfusions. Ward staff told us they preferred to keep patients on the ward, as they were aware of their individual needs. This had the potential to impact on bed availability. We were told that on occasion patients were asked to wait in the window bay area while they await transport.

Transport arrangements

Staff told us about concerns in relation to the patient transport arrangements provided by a private company. They expressed concerns that in the past patients had been missed from the transport list or collected late at night. Ward staff and the nurse in the discharge lounge told us there was no criteria for discharging patients late at night; it was down to staff discretion. We were given examples of when staff had escalated concerns and alternative transport had been arranged. On other occasions patients spent a further night in hospital.

Staffing levels

In response to increased demand for services we saw there had been an increase in the staffing levels. There had been

a successful recruitment drive and more nurses had been employed. An additional middle grade doctor now worked at weekends which enabled one doctor to treat inpatients and the second doctor to manage emergency admissions.

Privacy and Dignity

On the wards, we observed that patients' names and bed numbers were displayed on a white board by the nurses' station. Some wards also recorded whether patients required other services such as physiotherapy. This meant everybody who came onto the ward was able to confidential information about patients on the ward. We were told that the trust planned to introduce electronic whiteboards, which would address this problem.

We saw that ward multidisciplinary meetings were held at the nurses' station. Patients' condition, progress and social situations were discussed. This meant that anyone who was on the ward would be able to hear confidential information about the patients.

Within the operating theatre area patients' privacy and dignity were not maintained. We observed that patients' were asked to remove their top gowns, leaving only a theatre gown which was open at the back. This was done in an area where patients could be seen by other patients and passing staff. The patients were then assisted onto theatre trolleys and placed next to each other in an open waiting area. This area was next to a reception desk and busy theatre main corridor. Patients were able to hear discussions about other patients.

We were also concerned by some of the apparent consenting procedures. We witnessed that not all patients were consented prior to their transfer to theatres. There were laminated cards to indicate these patients, which implied that what we observed had happened previously. The Department of Health reference guide to consent for examination or treatment states that 'for major interventions, it is good practice where possible to seek the person's consent to the proposed procedure well in advance' and we would normally expect patients to be consented whilst on the ward.

Surgery

Are surgery services well-led?

Good



Nursing staff on the wards told us about the six Cs for nursing staff: communication, care, courage, compassion, commitment, and competency. They also mentioned the 15 Steps Challenge, which looks at quality from a patient's perspective. Information about these initiatives was displayed on noticeboards in the wards. Senior staff and lead clinicians had a good understanding of the way their department performed.

Staff told us they received appropriate training and talked about a new nursing strategy that had been developed by the matrons. Staff told us that working for the trust was a positive experience, and they said that a lot of staff were 'home grown'. We were given examples of how staff that had been supported to develop their skills and achieve promotion. One senior sister told us how they had been empowered by a matron to make decisions and take responsibility for what happened in their ward area.






The surgical directorate held monthly meetings where day to day issues and future plans were discussed. Learning from these meetings was cascaded across other directorates to ensure there was shared learning.

Staff at all levels told us there was an open door policy and the organisation was non-hierarchical. They were happy to escalate concerns to senior managers, if necessary. They told us all senior staff were approachable and the director of nursing regularly visited the ward areas.

Senior sisters told us about weekly meetings with matrons. This was an opportunity to discuss concerns and learn from incidents that had happened on individual wards. Matrons also provided feedback from their weekly walk-around visits, where they focused on a specific area. Other staff on the ward told us that information from these meetings was fed down to them. This meant they were aware of incidents and learning that had taken place.

Rotation for junior doctors had taken place two days before our inspection. Some doctors on the surgical ward told us they had received a comprehensive handover from the previous junior doctor. They told us they felt well supported by others in the team. A junior doctor on an orthopaedic ward told us that they had not received a handover from their colleague but felt supported by the other ward staff.

Intensive/critical care

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

Information about the service

The critical care services at the trust consist of a ten-bedded unit. There was also a critical care outreach team. We visited the unit on 6 December, spoke to staff and reviewed three sets of patient records.

Summary of findings

We found that the intensive care and critical care service was safe and effective. It was responsive to the needs of patients and had caring and attentive staff. We found that the unit was well led. Pressure was placed on the unit when transfer of patients was delayed due to bed occupancy challenges faced by the trust. Though the unit coped with the situation, these patients were cared for in a mixed sex environment and had to use the bathroom and toilet facilities in the adjacent ward. If beds were occupied by patients not requiring intensive care those who did require this level of support could not be admitted to the unit and in some cases treatment would be delayed.

Intensive/critical care

Are intensive/critical services safe?

Good 

The service was funded and staffed to support six level three beds and four level two beds. We looked at the rotas and talked with staff to ensure there were sufficient staff in place to support patients with acute needs. We looked at the number of incidents reported relating to staffing on the unit and found that there had been 18 in October and five in November. The trust had responded to the identified concern and the risk of impact on both the quality and safety of care. We saw that the issue of nurse staffing levels was included on the trust's risk register. A recent business case had increased the number of staff on the ward by 11, though some new staff were still completing training. Experienced staff had been appointed to maintain the skill mix needed on the unit.

We found that shifts were covered by staff allocated to the Intensive Therapy Unit (ITU). There was no use of agency staff on the ward. This ensured that higher-risk patients were being cared for by staff who knew their needs and understood how the unit operated. We found that new staff allocated to ITU were included on the rota as supernumerary for their first three months to ensure they met the required competencies of working in the department. When competencies were signed off, staff were then included in the shift numbers. This ensured that patients were kept safe by competent staff meeting their needs.

Staff told us that there was generally enough equipment on the unit. We were told that four new infusion pumps had been ordered for each bed and that all the monitors had recently been upgraded. ITU did not loan its equipment to other areas of the hospital, to ensure there is sufficient equipment available to meet patients' needs.

We looked at patient records on ITU and found that care plans and paperwork were all up to date and complete. There were mental capacity act assessments in place for all patients.

In other areas of the hospital we saw that staff were following the hospital policy of using a scoring system to identify adult patients at risk of deterioration (called PAR

scoring). At night the on site management team would visit ward areas and assist with the management of deteriorating patients. There was also a critical outreach team who assist with the management of these patients.

Information from the Intensive Care National Audit and Research Centre (ICNARC) from 1 July 2013 to 30 September 2013 showed that the trust had no unit acquired infections.

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

Good 

Information from the Intensive Care National Audit and Research Centre (ICNARC) show that the unit mortality rates are similar to comparable sized departments.

A practice development nurse on the unit was identifying training needs for staff to improve their competency and responsiveness to patient needs. For example, this included recognising the changing needs of patients and then using appropriate equipment to support their improvement.

We saw that nurses carried out ongoing reviews of practice on the unit. Risks they identified were reviewed at the monthly meeting of senior staff on the unit and then shared with other staff. This ensured that staff learnt and improved their practice and services developed to meet people's needs.

Are intensive/critical services caring?

Good 

We observed that there were good staff interactions with patients on the unit. We saw appropriate use of humour and encouragement with patients who were awake. Staff explained to patients what they were doing. Staff approached patients in a calm manner. There was a trusting and easy relationship between the staff and the patients.

Intensive/critical care

Are intensive/critical services responsive to people's needs? (for example, to feedback?)

Requires improvement 

The ability of the unit to function appropriately as an intensive care facility was being impacted on by the patient flow with patients having to stay on the unit when they no longer required intensive care. On one occasion a patient had remained on the unit for 7 days before being transferred to a general ward. Information from the Intensive Care National Audit and Research Centre (ICNARC) showed that the trust had a higher level of delayed and out of hours discharges from the critical care unit to both other similar units and the expected level. On the day of our inspection, five of the ten beds were occupied by patients waiting transfer to another ward in the hospital. Staff told us this occurrence was a daily issue and was linked to the limited number of beds available, which was caused by delays in discharging patients from acute care.

The unit did not have the facilities required by these patients, and they had to access bathroom and toilet facilities in the adjacent ward. The ITU was also mixed gender on the ward. The Intensive Therapy Unit would be expected to be a mixed sex ward during the time patients required intensive care, but people's privacy and dignity were being affected by the length of time they had to wait to be transferred to a ward when they no longer needed to be on the unit. Patients' privacy and dignity were further compromised because of the limited facilities available to them.

In response to this the ITU had introduced a buddy system with medical wards in the hospital to improve working

relationships that would facilitate quicker step down arrangements between them. Staff told us this was having a positive effect in moving patients into more appropriate wards as their condition improved. This demonstrated that the service was working collaboratively to provide a better service for patients.

We were told there had only been one complaint in the last 18 months on the unit. The complaint had related to a pressure ulcer. As a result of the complaint, staff had undertaken a structured teaching session for all critical care staff to ensure that staff understood how to effectively care for people at risk of pressure ulcers.






Are intensive/critical services well-led?

Good 

Staff told us that the matron and senior staff were visible on the unit. They demonstrated up-to-date knowledge and were available to offer support to staff when needed. We observed that the team was motivated and supportive of each other.

There was a comprehensive training programme in place, including access to a range of study days. We saw that competence assessments were supported by evidence that demonstrated that staff skills were reviewed and experience developed. We saw that staff were involved in determining their ongoing learning needs, which were recorded. There were self-assessments in place for staff to review their competence in using medical devices used on the unit. This ensured that practice standards were maintained. The staff files that we reviewed showed that induction, appraisal and competency assessments were up to date.

Maternity and family planning

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

Information about the service

Women who use the maternity services at the trust can choose delivery booked under the care of the midwife/ shared care or with the consultant obstetrician. The maternity teams offer an antenatal clinic, home birth service, a co-located midwifery led unit, a delivery suite, obstetric theatres and a special care baby unit.

The delivery suite has eight en-suite delivery rooms, a high dependency room, a two-bedded recovery area and two obstetrics theatres. It provides intrapartum care to women assessed as both high and low risk. Cedar Ward is a twenty bedded maternity ward that provides care to high risk antenatal and postnatal women. Tambootie Ward is a foetal assessment unit providing triage, assessment, advice and a plan of care for women. Aspen Ward is a co-located midwifery led unit. It has four birthing rooms and facilitates for water births. It provides intrapartum and immediate postnatal care to low risk women.

There is also a transitional care unit co-ordinated from the special care baby unit. Walnut ward is the special care unit, and there is an early pregnancy diagnostic unit based on Mulberry ward.

In 2010/2011, the Women and Paediatric Directorate delivered care to 4,200 women and their families and in 2012/2013, 5,085 babies (5,011 mothers) were delivered.

Summary of findings

We found that the midwifery unit provided safe and effective care for women. Feedback from women using the service was positive. They told us staff were kind and sensitive to their needs and said that they were given effective advice and support in their chosen method of feeding their babies. The service was well led with clear shared goals and objectives, which were known to all staff we spoke with. Women said they had been well supported throughout their stay in the maternity services.

Women using the maternity service could be confident they would receive safe care during their pregnancy and birth of their babies.

Maternity and family planning

Are maternity and family planning services safe?

Good 

Safeguarding

Staff training records confirmed that over 85% of staff were trained in safeguarding children. Staff were clear about the training and their responsibilities. The trust's mandatory bi-annual 'Managing risk in the workplace' training included basic adult and children's safeguarding training.

Since June 2011 there had been an increase in the number of staff trained in the completion of the common assessment framework (CAF) process. This had occurred in response to staff concerns about the process in relation to the child protection framework. This was listed on the risk register for the directorate, which stated that any confusion in the process could delay patients receiving appropriate services from the local authority. Staff who had attended this training told us they found it useful and said that it had improved their practice.

Staff members told us there were good working relationships across maternity and children's services in relation to safeguarding children. For example, senior midwives in the maternity assessment unit, the special care unit and the early pregnancy diagnostic unit told us they regularly contacted a named nurse on the children's ward. This nurse was available for advice and support on issues about child protection and safeguarding. From September 2013 midwives' child protection training had been elevated from level 2 to level 3 to increase their knowledge and understanding of safeguarding children.

The maternity risk register identified that there was no clear system for supervising the day-to-day child protection and safeguarding work of midwives and children's nursing/medical staff. The trust had identified the need for an additional staff member to provide safeguarding supervision in order to address this potential shortfall in safe practice. A business case had been put forward for a senior nurse to take a safeguarding children's lead role across the trust.

Staff had completed training in the Mental Capacity Act 2005 but had not received any training specifically on the Deprivation of Liberty Safeguards (DoLS). All the staff we spoke with were unaware of these safeguards and how they could impact upon their practice.

Infection control

Patients were protected from the risk of infection. The hospital ensured patients and visitors were safe from avoidable *Clostridium difficile* (C. difficile) and methicillin-resistant staphylococcus aureus (MRSA) infections by regularly reviewing and monitoring the risks and taking effective action. A staff member told us they were well supported by the infection control team. We saw written evidence of mandatory training for all staff in infection control policies and procedures. Staff members told us there were regular hand washing audits to ensure the policies were followed. We saw staff adhered to the 'stripped bare below the elbow' policy.

Patients and visitors were provided with information on how to prevent infections. On each of the wards we visited we saw that staff reminded visitors to clean their hands with the hand hygiene gel. Monitoring of the infection control procedures was completed by the Infection Control Committee. There was a regular review of the antimicrobial prescribing policy and a system of monthly audits of prescribing. There was also continuance surveillance of antimicrobial resistance.

We saw patients were cared for in a hygienic, clean and comfortable environment across all the maternity services.

Staffing

Staff told us there were sufficient numbers of staff to provide safe care. The NHS Litigation Authority and the Safer Childbirth report produced by the Royal Colleges state that the ratio of midwives to births should be 1:28. The current midwife to birth ratio within the maternity service was 1.32. However, there were systems in place to ensure there were sufficient staff to meet the care needs of women using the service. These included a recruitment plan and regular and ongoing workforce planning. The delivery suite co-ordinator was able to allocate midwifery staff according to case and skill mix, there was a maternity triage system in place with staff rotation across maternity wards and there was a staffing and maternity escalation policy in place. To ensure consistency across the maternity

Maternity and family planning

triage there was a daily check list for staff to ensure the safe care of patients when staff rotated across the maternity areas. One midwife told us, "It can be busy but I don't feel rushed off my feet."

Staff completed risk assessments about women's safe care. We saw detailed initial assessments, and care and treatment plans that included preferences for birth planning. There was a system to record incidents and accidents which were reported to and monitored by the clinical governance boards. There was a Maternity Harm Free Care Strategy which included the development of the safety thermometer (a system for identifying potential risks) in the maternity service to improve patient safety and minimise risks.

The head of midwifery told us that since 2010 the service had recruited three consultants, taking the total number to 12 across the service. They identified that there was a "shortage of middle grades" as "it was difficult to recruit". They told us a business case to the Board had been approved for additional recruitment.

Records

Patient's records were well maintained. The electronic recording tools included the patient care IT system and the Euroking (ES) system. The ES system included information about patients' medical histories, and family and social history. Once delivery had taken place, the records were updated to include the delivery details, for example the time the baby was born. Alongside this online record were handwritten case notes which included the antenatal care pathway, labour care pathways and the postnatal care plans, including discharge. A staff member told us, "Timely discharge is always a challenge when we are busy, but we don't have any major concerns about it. We communicate well across the service so that helps."

The patient centred system alerted staff to safeguarding or MRSA concerns. This alert indicated to staff there was more information available within the hospital notes.

Records were audited at supervision meetings. We were told staff audit two sets of another staff members records using the audit tool to make sure the records were consistent, and staff members understood both the recording system and the care pathways. We saw evidence that on staff maternity study days there were training

sessions for midwives on writing care records. A staff member told us, "This was to ensure patients' case notes ensured that care was delivered in line with their treatment plans and to identify any future risks."

Are maternity and family planning services effective?

(for example, treatment is effective)

Good 

Core values and nursing and midwifery strategy.

All the staff we spoke with were aware of the core values of the trust and they were able to give examples of how they put these values into practice. All staff were aware of the nursing and midwifery strategy for 2012/2014. The summary of the strategy stated the "ten ambitions for the strategy were chosen with core principals in mind including the objectives of the 2012/13 Trust Quality Strategy and 'Our Behaviours' and these mirrored the ten standards contained within the Patient Service Standards (November 2011)." We saw that staff members also worked towards Dartford and Gravesham's NHS Trust's 'Working Well together' initiative, which was launched in November 2008 to set out to staff and managers the behaviours the trust expected them to demonstrate. One midwife told us, "We are very proud of this strategy, and it has made improvements to the service we can deliver. We have a very good reputation locally, and people will travel a long way to come here."

Clinical audits and guideline use

Staff work to the Safer Childbirth guidelines of the Royal Colleges. There were clinical audits to ensure the service was working to the National Institute for Health and Care Excellence (NICE). For example, there was a pregnancy plus midwifery led service for women who began pregnancy with a larger body mass index (BMI).

Midwife supervision

There was a supervisor of midwives available for staff support and advice. Midwives told us they had twice-yearly statutory supervision of their practice. These were minuted and an action plan devised. Personal development and mandatory training were available for all staff.

Maternity and family planning

Food

Staff confirmed patients received sufficient food and drink to assist recovery. Staff members could describe patient special dietary needs and told us patients could get hot meals at any time. They told us patients' dietary requirements in relation to their cultural needs could be accommodated. A midwife told us relatives could bring in a patient's favourite food.

Are maternity and family planning services caring?

Good 

Patient feedback

Women were very positive about the staff. They told us staff of all levels were kind, considerate and sensitive. They told us they were treated with both dignity and respect. One woman told us, "They are very respectful about the need to reduce the noise at night. They make a real effort. It's important to me to get good night's sleep." A midwife told us, "I treat people how I would like to be treated."

One woman told us, "Even though they're busy, they try to spend time with me to help me with breastfeeding." Women told us they were mostly given the information they needed to make informed choices about breastfeeding and delivery. One patient told us they had received different levels of advice from different consultants, which they had found "difficult". Another patient told us they were kept informed at all stages of giving birth. Another patient told us their pain relief was "well controlled and quickly delivered". They told us they would recommend the maternity service to other people. Another woman told us they had chosen to use the birthing pool and staff were "very caring and helpful to me".

Women told us they felt they had been given sufficient information from the staff team to allow them to make informed choices about their care and treatment. Women told us their birth plan was important to them and they valued being encouraged to be involved in the process.

Staff

On all areas of the maternity service we visited we saw the staff answered buzzers quickly and efficiently. One woman told us, "We don't have to wait long." We saw staff interactions with people were kind and considerate. A staff

member told us, "We have a can-do attitude here. Some women can be very anxious about giving birth so it's important they know what to expect and what we can do to help."

We saw the wards were calm and peaceful. One staff member told us, "Caring for people well is really important to me. I love it here."

We read the recent patient feedback on the Hospitals website and saw how one woman had been so impressed with the level of care she had recently received she had decided to become a midwife herself.

Patient's privacy and dignity

We saw staff were respectful when speaking to the women on the wards. One midwife told us how they ensure they address people by their chosen name. One midwife told us that ensuring woman's dignity when giving birth was central to their ethos.

We saw staff assist women in a sensitive and kind manner. The wards were seen to be calm and homely.

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

Good 

We found that maternity services were responsive to people's needs.

In August 2010 the maternity services monitored the assumed and actual maternity activities and asked how they could be responsive to the identified increased maternity needs of the community. They identified:

The impact of closure in the neighbouring acute maternity facility in December 2010, which resulted in 1,500 women with significant clinical complexity transferring to the service.

An increasing number of bookings from Essex and a potential growth in the local Kent population.

This led to increasing the midwife to birth ratio 1:33 in June 2013 to 1:32 in October 2013.

In July 2011/January 2012 the service moved into the maternity escalation process due to bed capacity issues. As

Maternity and family planning

a direct result of these incidents a formal review of the maternity facilities took place and £140,000 capital bid was successful in January 2013. This funding was used to create six additional beds within the maternity service to meet the growing needs of the community.

In December 2012 the service was allocated £100,000 by the Department of Health. With this allocation it refurbished the midwifery-led unit pool facilities. It developed facilities for partners who needed to stay overnight. We were told this immediately halved complaints from friends and family. The service also upgraded the delivery suite reception area and bereavement facilities. In theatre we saw the designated room for women who had experienced bereavement. The room was decorated with woodland pictures, creating a private and peaceful space.

The separation of the postnatal ward and the birth centre was described in the Celebrating Success in Maternity newsletter as “a new approach to the normality midwifery pathway which gives women enhanced choices, access and facilities in their birth experience”. One woman told us, “It was so relaxing... the best for me and my baby.”

The head of midwifery told us, “Whatever the woman says is of absolute importance,” and this “learning informs our strategy planning and influences the goals of our five year plan.”

Are maternity and family planning services well-led?

Good 

The service was well led.

All staff we spoke with told us they were well led and had strong leadership. Staff were positive about the reorganisation of the management of wards like Cedar and Aspen so that each had separate ward management. One staff member told us, “We all work to the same objectives. We know what these objectives are, as they clearly laid out in our midwifery strategy.”

Staff were able to describe the plans for the future, and these included plans for core elective medical and maternity services. The Chief Executive of the trust had clearly identified areas for further development. These included addressing the challenges within maternity services of meeting the needs of mothers with mental health needs.

Staff told us the midwifery strategy was incorporated into their day to day work. For example, the maternity department’s leadership were visible. Midwives told us senior managers and consultants were “approachable, supportive and visible”.

There was a comprehensive system for governance of the service. These included frequent Directorate Governance meetings. Risks identified on the risk register were discussed at these meetings. Ongoing actions in response to these risks were updated to provide safe care for women using the service.






There were effective systems to ensure information was disseminated from the Board to ward. These included ensuring staff had access to the internal website screen ‘pop-ups’, newsletters, information on ward noticeboards, daily updates in communication books, training updates via emails and a system of daily ward meetings and handovers between each staff team.

The Quality and Safety Team monitored significant maternity/gynaecology incidents and any maternity coroner’s cases. Maternity risks were included on the trust’s risk register.

One staff member told us, “They really listen to and value what we say here.” For example, we were told the delivery unit made a successful business case for an additional registrar, and facilities for women’s partners to stay overnight on maternity wards had originated from complaints from patients using the service.

One midwife told us, “We work as a team. It’s a good place to work.” A junior doctor said “that the midwives are very good and work well with the medical teams”.

Services for children & young people

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

Information about the service

The main children's ward is Willow Ward at Darent Valley Hospital. The ward has 22 beds and admits children from the age of 0 to 16 years. It occasionally admits children up to 18 years of age. Children are admitted to Willow ward with a wide range of medical, surgical and orthopaedic complaints. Children are admitted in various ways including: via the accident and emergency department; direct from home (via the Community Children's Nursing Team); via outpatients; or via GP referral. The ward is staffed by a team of dedicated children's nurses who are supported by: healthcare assistants; a team of play specialists; an outreach hospital teacher; and clerical staff. The ward has a wide range of facilities to care for children of all ages, including adolescent facilities and the ball pool, children's garden, play room and a computer den.

There is a Paediatric Assessment Unit (PAU) based on Willow ward. The unit consists of four beds and one cubicle and has its own waiting area and assessment room. The unit is currently open seven days a week from 8.30am to 9pm. The unit is dual function, with nurse-led services provided by experienced paediatric nurses and nursing assistants, supported by middle and junior grade doctors to facilitate both ward attendances and rapid transfer of children requiring further assessment or paediatric observation. It also operates a GP referral system whereby children can come directly to the unit for paediatric review. Children referred to the unit for further assessment or observations are assessed by a senior paediatrician and paediatric nurse. The aim is for children to be observed and/or treated for a maximum of four hours in PAU or to discharge. If assessment and/or treatment is deemed to require a longer period of admission, the child is transferred to an inpatient bed on Willow ward.

The Neonatal Unit / Special Care Baby Unit (SCBU) is on Walnut ward. The unit cares for newborn babies who are either preterm or require a higher level of medical and nursing care following birth. The unit has 24 cots, including four high dependency cots. There are also facilities for parents to stay with their babies before discharge. They cater for preterm babies of more than 30 weeks gestation, sick term babies and referrals from tertiary units of babies who have required long-term intensive care.

The Children's Resource Centre merges paediatric community services and acute outpatients to form a combined child health service. The children's outpatient teams see approximately 100 children per week and support the community team, which sees approximately 360 children from 0 to 16yrs of age. There is a further children's outpatient facility at Queen Mary's Hospital.

The Community Children's Nursing Team (CCNT) is based in the Children's Resource Centre. The team of children's nurses offer a five-day community service to children and adolescents who have recently been discharged from Willow or Walnut ward, or if they require nursing care, support or education at home.

We visited Willow ward, Walnut ward, the PAU and the Children's Centre. We spoke with four children and five parents. We spoke with a number of staff, including a matron, consultants, junior doctors, nursing staff and administration staff.

Services for children & young people

Summary of findings

In the main children's department, parents told us that staff were responsive to their needs and that they listened to them. They were included in decisions about the care and treatment of their children. They said staff responded quickly to requests for assistance. Patients received safe and effective care and treatment. The environment was well maintained and engaging for young people. There were sufficient numbers of staff on the wards and in the outpatient area, and there was a system for the management of staffing levels and skill mix to ensure children were cared for safely.

This was not the case in the A&E department, where there was an insufficient number of nurses qualified in the care of children. We also found in the A&E department that national guidance was not being followed in relation to the management of pain in children.

The trust was monitoring the quality of the service and making changes where they were needed. The views of children and families were being used to inform the service provision in the main children's department. There was a team in place to monitor and address any safeguarding concerns, and the trust had planned further developments.

Are services for children & young people safe?

Good 

Infection control

All the areas of the paediatric service we visited were clean and tidy. Staff training records confirmed that training in infection control policies, procedures and cleaning systems had taken place. There were cleaning checklists and schedules to ensure all areas were kept hygienic.

We saw staff encouraging patients and visitors to wash their hands on arrival to the ward and at regular intervals. There were arrangements in place for the safe storage and disposal of sharp and contaminated items. We saw protective personal equipment like gloves, aprons and eye protection were used by staff members to ensure the safe care of patients.

Equipment was stored hygienically, ready for the next patient's use. There were individual rooms for patients who had infections so that they could be isolated from others to reduce the risk of the spread of infection.

Staffing

Discussions with the staff team and a review of the staffing rotas confirmed there was an effective staff rostering system in place for effective planning of staff numbers and skill mix on any given shift in the main children's department. One parent on the children's ward told us, "Staff give us the time we need to talk about our children."

This was not the case in the A&E where there was not always a nurse qualified in the care of children on duty in the separate children's area of the department. Staff told us that there were sufficient numbers of nurses trained in the care of children to cover 16 of the 21 shifts each week, which was confirmed by the records we viewed. Staff told us that the uncovered shifts were filled with agency nurses who were either trained in the care of children or trained in the care of adults in an emergency department. They told us that when agency staff were not available to fill a vacant shift in the children's area a nurse trained in the care of adults was moved there from the main department. This meant that children were not always cared for by suitably skilled and qualified staff to ensure their needs were met safely. For example, we saw that on two days of our

Services for children & young people

inspection a nurse trained in the care of adults had been moved from the main department into the children's area to cover vacant shifts there. On another day of our inspection we saw that one twilight shift in the children's area was not filled. All children under the age of one were seen by a paediatrician.

Staff told us there had been concerns about children receiving appropriate medical attention when concerns were escalated to doctors, particularly on weekends and after 5pm on weekdays. In response to this the paediatric service adopted the consultant of the week (COW) model in November 2012. This was in line with the Facing the Future Guidance issued by the Royal College of Paediatrics and Child Health ensuring a named consultant was available between 7.30 am and 5pm, five days a week. All staff members spoke positively about this development. One staff member told us, "There is always someone senior to answer questions."

In addition, the trust had recently ensured that two paediatric registrars were available twenty four hours every day. Consultants also completed a late evening ward round, which occurred at some point after 7pm, depending on the needs of the service. Ward rounds took place daily, including the weekends.

The Special Care Baby Unit on Walnut ward was well staffed (1:2 for the high dependency unit and 1:4 for the rest of the unit). Staff spoken with felt there was sufficient staff to spend time with patients.

Early detection of deterioration

There was a system in place called the paediatric early warning system (PEWS), to identify child patients at risk of deterioration. In the A&E Staff told us that there was no policy in place governing the use of this system in the A&E department. We saw that the PEWS scoring system was not used on all children in the department. Staff told us that they made their own individual clinical decision on when to use the PEWS scoring system. This meant that children were being placed at risk as systems in place to help identify at risk children were not consistently being used. We were also told that adult nurses moved to the children's area of the department to cover vacant shifts were orientated to that area of the department by spending "a few" shifts shadowing a children's nurse there. Staff told us that there was no other specific training on the assessment

of children given in the department to adult nurses working in the children's area. This meant that children were not always assessed by a nurse with adequate training to assess them safely.

Safeguarding

Following an incident in 2012 the children's department had identified the need for an additional staff member whose role would include the supervision of staff safeguarding practice. The safeguarding lead role was currently incorporated into the matron's role, and the matron was supported by a safeguarding nurse. There was also a safeguarding team, which we were told visited the children's ward, maternity and the special care baby unit on a daily basis.

There was an established system for health visitors to be informed when a child had been admitted to hospital, and attendance at the accident and emergency department was monitored. We saw that there was a system to ensure that any child who had a child protection plan in place was known to the trust. In this system a 'flag' was placed on the computerised electronic system to alert staff. While the hospital also received information identifying children considered to be of concern, there was no established system in place for the sharing of this information, though it was available to members of the trusts Safeguarding Children Team.

We viewed records which demonstrated that the trust's safeguarding team was actively involved in discussion and decisions about children, where concerns had been identified. Clearly written records of discussions and the agreed actions were maintained. We saw that these included action to be taken on the discharge of the child.

Equipment

There was a risk register in place that was monitored by the risk and audit group. This showed that risks were monitored and action taken. For example, the risk register identified that there was a risk of patients in the children's units harming themselves with blind cords. The ward sister told us they had been removed, and they were currently seeking alternative solutions. On Walnut ward there was concern there was insufficient vital signs monitoring equipment. If one was out of service there would not be enough equipment available. The ward sister told us they could use an alternative monitoring system and there were plans in place to acquire additional vital sign monitors.

Services for children & young people

Are services for children & young people effective?

(for example, treatment is effective)

Good 

Audits

There were many audits in place to ensure the safe care of patients, and these included audits for: feverish illness in children, in line with NICE guidelines; head injuries in children; and paediatric asthma. There was an audit of recent medication errors and it was consequently decided that the consultants would also get a copy of the drug errors in order to achieve improved monitoring systems.

A College of Emergency Medicine audit told us that while the trust was in the top quartile for the administering of pain relief to children it had declined to almost 0% for analgesia wholly within guidelines.

There were inconsistencies in the assessment and recording of children's level of pain. We looked at ten records and saw that a pain score had only been recorded on five of them. We saw that three children had been given analgesia (pain relieving medication) but no pain score had been recorded. The records demonstrated that when analgesia was required it was given in a timely manner (within 60 minutes of arrival). However, we saw that for the five children given analgesia their level of pain was not then subsequently reassessed. This meant that children's pain was not being monitored effectively.

Collaborative working/coordinating transfers

A staff member told us there was good collaborative multidisciplinary working between maternity and paediatric services within the trust, particularly regarding the sharing of information about safeguarding issues.

They described how the neonatal unit worked in partnership with the Kent Neonatal Network to ensure babies were cared for in the most appropriate setting, depending on their clinical need. Staff had a clear understanding of their role in co-ordinating the transfer of patients to other local hospitals. There was close liaison with the retrieval service to ensure effective transfer of patients to other hospitals with appropriate equipment (for example a cot). One staff member had worked as part of

the retrieval service and stated this helped in effective planning for discharge. Medical notes that included transfer information were sent promptly to the receiving hospital to ensure continuity of care.

One staff member told us there was good inter-directorate working between the ward and women's services. One person told us their patient care, involvement in care planning and discharge, and the support they had received from staff in the neonatal unit were "very good".

Communication

Staff in the safeguarding teams sited in the paediatric ward told us of they had frequent communication with staff in the paediatric service. The staff on the paediatric ward told us they valued the proximity of the safeguarding team and it "led to good communication and effective working together to protect vulnerable children". The safeguarding nurse told us if there were safeguarding concerns about a child that they had good communication and liaison with health visitors, school nurses and the local authority safeguarding teams. They also described effective communication with the accident and emergency department (A&E) in the trust. They told us they received information from A&E about any concerns/ treatment for children who were known to the service. They told us, "I always make a point of visiting A&E myself daily to make sure I'm aware who is there and make sure we have a consistent service."

Assessment and care plans

There were several pathways for admission to the children's ward. A patient younger than one year old could have their medical and care needs assessed directly on the assessment unit sited on the paediatric ward. Once the assessment had been completed they moved onto the children's ward.

Staff told us patients with endocrine concerns (for example a child with diabetes) who had previously been treated on the ward or were known to the children's service could also be admitted directly to the ward.

Another pathway to the children's ward was via A&E, where patients followed the triage system before being admitted to the paediatric ward. Staff told us the most effective pathway for admission to the paediatric unit was via their own assessment unit and spoke positively about this "timely" service.

Services for children & young people

We saw staff used the assessment information effectively to inform patients' care and treatment plans. The assessment information also informed the risk assessments for patients' safe care. Staff had a good knowledge of the content of the care plans.

Effective systems

A staff member in the children's outpatients department told us they had recently reviewed the systems for alerting senior staff when children did not attend their clinic appointment. We were told that if patients did not attend the actual appointment the consultant was informed. It was then their responsibility to ensure that action was taken, either rescheduling an appointment and/or informing the GP.

An appointment could also be cancelled by contacting the receptionist at the appointment desk. If this occurred an appointment could be rebooked. The consultants' secretaries were clear that there was a procedure in place to follow up any children who did not attend clinic appointments. They confirmed that a child's GP would be contacted when a child did not attend twice in concession. This process had been reaffirmed by a letter sent to staff in May 2013 from the trust's safeguarding lead. The aim of the system was to ensure that there was an effective follow-up system in place.

Staff competence and development

A senior staff member in the neonatal unit and staff on the paediatric wards told us staffing levels had recently improved with the appointment of an additional paediatric registrar. The consultant on call would be expected to visit the unit in the evening to review patients. They also confirmed that all children under a year old (including those in A&E) were seen by a children's doctor. We were told that all nursing staff had an annual personal development review, which covered their developmental and training needs. Training records provided by the trust showed that 81.3% of staff in the children's directorate had completed their mandatory bi-annual 'Managing risk in the workplace' training.

National Guidelines

In the A&E staff were not always able to access current national and good practice guidelines to deliver safe care. On 5 December 2013 we looked at wall-mounted documents and a ring binder that contained out-of-date and incorrect national and good practice guidance on patient care. For example, we saw guidance on the

management of pain in children dated 2006 that directed staff to use a pain relieving drug no longer appropriate for administration to children. When we mentioned this to staff they told us that there was not currently a system in place to ensure that all national and good practice guidance on patient care was updated with current guidelines.

Are services for children & young people caring?

Good 

On the paediatric ward we spoke with a relative of a patient with a learning disability. They told us their experience on the ward was "positive". They had experienced "good" care and treatment planning. They were clear about the discharge plan in place and told us the staff had been "clear" and "kind".

Staff were kind and thoughtful in their care of patients across the children's services. Staff spoke warmly about their work with children on the wards, their assessment unit and the special care baby unit. We observed compassionate care being delivered by staff.

We observed good patient-centred, multidisciplinary ward rounds that included pharmacists. We saw staff informing children and their families about the treatment they were to receive in a calm and kind manner. In one ward we saw three doctors complete a ward round and saw they made a point of including relatives in their discussions about their children. We also saw they altered an oxygen mask to make sure a patient was more comfortable.

In Willow ward there was a selection of other toys and games for the children to play with and make their stay more pleasant. We were told staff "went out of their way to get a console for one child so they could play a computer game. Their parent told us, "It was really kind."

Staff provided patients with the information about what to expect on the unit and the variety of services available.

We spoke with a relative of a patient who was admitted for an asthmatic condition. They told us that they felt included in the treatment plan and that the patient had made friends with two of the nurses so was feeling more relaxed. Another relative told us they would recommend the unit it to their friends.

Services for children & young people

A staff member told us they felt there was a “good team spirit” and staff were well supported particularly one staff member requiring a phased return to work.

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

Good 

Responsive

Staff on Walnut ward told us that in order to obtain feedback parents were encouraged to complete a patient satisfaction survey and that the response rate was very good. The results were collated by two nurses and the results fed back to the team. We were told that the results would be used to ensure people received the service they wanted.

While staff said they were aware of how to report accidents and incidents and that they were encouraged to make reports, they felt that they did not currently receive feedback on anything they did report. We were told that this had been raised at a staff meeting. We saw in the minutes of the directorates risk and audit meeting that this had been discussed and that plans had been put in place for comments to be added to the reports on the reporting system.

Some staff raised concerns about the timeliness of responses by the Child and Adolescent Mental Health Service (CAMHS) for assessments of young people with mental health concerns on the children’s wards. A nurse told us, “I have to call them between 9am and 10am in the morning if I want an assessment the same day, and this is not always possible.” We saw one young person was awaiting a CAMHS assessment. They had been admitted at 6.45pm the day before and still had not been seen by 11pm the following day. The situation was being managed by staff supervising the individual at all times.

Education

We saw there were facilities for patients to receive educational input whilst on the children’s wards. Leaflets were displayed in an education folder in a designated area.

Privacy and Dignity

In the A&E triage in the children’s area of the department could be overheard. These interviews included the sharing of personal confidential information. Similarly we observed that handovers and other discussions between hospital staff at the nurses’ stations could be overheard. These discussions included treatment plans as well as personal information. This meant that patient confidentiality and privacy was compromised.

Are services for children & young people well-led?

Good 

The service is well led.

There were regular paediatric risk audit meetings as part of their departmental clinical governance system. These were attended by staff from across the paediatric service, including the consultant paediatrician, senior sisters from Willow ward and the special care baby unit, and also the clinical audit manager. We were told the meetings had recently been moved to Friday afternoons to ensure they were well attended and saw this was being monitored on the risk register for paediatric services.

The minutes of these meetings confirmed the service was effectively monitoring the delivery of care for patients across the paediatric service. For example, the minutes of the departmental meeting dated October 2013 identified improvements in the datix system used for recording incidents. It was agreed these entries were to include any action taken and any feedback from the incident in order to develop their learning.

We saw there were policies and procedures in place to support the effective monitoring of incidents within the paediatric service. Any patient safety incidents were reported to the Patient Safety Committee. The trust investigated serious incidents, and subsequent actions were monitored by the Clinical Governance Committee and The Board of Directors. Incidents were also reported to the national Reporting and Learning Service, which was run by the National Patient Safety Agency.

We saw the trust responded effectively to serious incidences and learnt lessons from these events. For example, it has introduced an early warning score system

Services for children & young people

(with escalation guidelines) that has been piloted on the children's ward. At the end of the pilot there will be an audit of how accurately it was used by the staff in the children's service and specifically the staff compliance with this tool. The audit will then be included in the report to the trust Quality and Safety Committee for further monitoring and evaluation.

There had been a review of the induction for locum children's doctors. This included regular teaching reviews

for junior and middle grade doctors with experienced consultant paediatricians. We were told this was to develop reflective practice about the decisions they made in any incidents.

Staff at all levels were positive about the support they received from consultants on the wards and senior managers. There were monthly ward meetings, team briefs and online information to ensure staff were kept informed of developments in the trust.

End of life care

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

Information about the service

Dartford and Gravesham NHS Trust had a nurse-led palliative care team. The palliative care team provided services for patients with progressive and incurable illnesses, and support for families and carers. Not all patients referred to the palliative team were at the end of life stage, but they did require support and advice to manage pain and symptoms of progressive illness.

Patients receiving end of life care were cared for on wards throughout the hospital. There were no specific palliative care wards. We visited five wards providing end of life care. Staff told us that they were able to contact the palliative team 24 hours a day and that the team responded quickly to provide advice and support.

The palliative care team used a fast-track pathway tool for rapidly deteriorating patients and facilitated rapid discharges for people wishing to return home. The team worked closely with all medical, surgical and speciality teams involved in patients care. This evidenced that effective multidisciplinary team involvement took place whatever ward patients were admitted to. The palliative team also had close links with community services including the local hospice, and hospice at home care services.

We visited five wards, the bereavement office, the hospital mortuary, the ablutions room and the chapel / multi-faith room. We looked at the care records of five people who were receiving end of life care. We met with members of the palliative care team, the cancer lead nurse and staff working on all the wards visited.

We also looked at oncology services provided at the hospital. The trust had recently developed a 24-hour

oncology service. We visited wards providing oncology care, including the chemotherapy unit. We reviewed care records and spoke to eight patients and their family/carers when possible.

End of life care

Summary of findings

We found that end of life care provided at the trust was safe, effective, caring, responsive and well led. The trust no longer used the Liverpool Care Pathway and was in the process of reviewing its end of life pathway. The palliative care team worked closely with staff on wards to ensure that patients had individualised end of life care provided in a positive, supportive environment. The team also had close links to community services. Patients and their families were involved in decisions about care and treatment in a dignified, respectful manner. Staff spoke positively about the support they received from the team. They felt this improved the patient experience and ensured patients received choices regarding end of life care and treatment.

Are end of life care services safe?

Good 

Patients received safe end of life care. In line with national guidance the trust no longer used the Liverpool Care Pathway. We spoke with consultants, doctors, junior doctors, matrons, senior sisters, staff nurses, ward clerks and nursing assistants. Staff spoken with told us there was no new pathway in place at the time of our inspection. However, all staff spoken with were aware that they needed to refer patients to the palliative team and spoke very positively about the help and support they received.

Staff we spoke with told us they had received end of life care training provided by the palliative care team. This included pain relief, training in the use of syringe drivers for the delivery of medication, and breaking bad news. We were told by the palliative care team that it advised staff on appropriate communication, and the importance of individualised care for patients with end of life care needs. Staff we spoke with on the wards told us that they contacted the palliative team and received advice, support and one-to-one training when needed.

Care documentation

We looked at the care records for five people on five separate wards. All of these patients had been referred to the palliative care team. End of life care plans were seen in all files viewed. These included core care plans for end of life care and information documented by the palliative care team. End of life care plans were personalised and reflected each person's choices and decisions. For example, one end of life care plan informed staff that the patient had chosen not to have any invasive treatment, therefore blood tests and cannulation need not be done. Pain relief had been documented, and reviewed regularly by the palliative care team. Care plans were personalised and had been developed to support the individual's needs. Documentation also included clear information and evidenced patients and their families had been involved in the decisions made.

We saw in one care plan that a patient had a pressure ulcer. We tracked this incident back and saw that an incident form had been completed when this had occurred. In response to this incident an action plan for the delivery of pressure ulcer management had been devised. We saw

End of life care

that this included learning from the incident, with staff involved in feedback and recommendations made. One of the recommendations was for the ward to trial a 'black dot system'. This was used on the patient information white boards which were located in a staff only area. The black dot was used to identify patients at risk of, or who had, pressure ulcers, and it was used in conjunction with appropriate assessments and documentation. We saw that repositioning had been checked regularly. All pressure ulcer assessments and plans of care had been checked weekly by the ward sister. This had meant that pressure area care had become embedded into practice for staff, and had improved patient safety.

Do Not Attempt Resuscitation forms

These forms are used to ensure that decisions about not attempting cardiopulmonary resuscitation were clearly documented and the decision shared. The records viewed contained Do Not Attempt Resuscitation forms. We saw that forms had been completed with patient, family and multidisciplinary team involvement in decisions documented. This meant that clear documented decisions had been made about people's end of life care choices.

The palliative care team attended weekly multidisciplinary meetings. This included a review of all patients currently on wards who were receiving end of life care. This meant that patients care was discussed and reviewed regularly.

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

Good 

Patient's end of life care was managed effectively. The palliative care team was in the process of transition, as the service had been taken over by the trust in October 2013. The service was being reviewed to ensure a continued visible, available and accessible service 24 hours a day.

The palliative care team also facilitated rapid discharges for people wishing to return home, and worked closely with multi-disciplinary team and community services including the local hospice and hospice at home care services.

The specialist team consisted of five nurse specialists and one part time end of life care facilitator, who worked across

all wards and departments of the hospital. Consultant support was available Monday to Friday with an on-call consultant available out of hours at the local community hospice.

The trust provided a 24-hour helpline for patients offering advice and support. We were given examples of how this service had been used for patients who were hearing impaired, with a texting facility implemented. Further examples were given to us on how language barriers and other communication limitations had been managed; this included the use of an interpreter. This demonstrated that action had been taken to ensure that the service was available to all. A further 24-hour telephone service was available for staff requiring verbal advice regarding the treatment for patients receiving end of life care.

Systems were in place to redesign the end of life care pathway. The palliative care team showed us the end of life care strategy, and told us that plans were in place for a MDT meeting which would include input from a nurse consultant, end of life facilitator and the palliative care team. This was due to take place with an aim to produce a new end of life pathway by February 2014.

We spoke with staff on oncology, medical, surgical and critical care wards. All ward staff we spoke with told us that the palliative care team responded swiftly when referrals were made. Despite the changes to the service and the discontinuation of the Liverpool Care Pathway, systems were in place for staff throughout the hospital to access the palliative care team, receive appropriate training and complete documentation around people's end of life care needs. This ensured that people received appropriate care, treatment and advice.

Are end of life care services caring?

Good 

End of life care services within the hospital were caring. We spoke with staff and patients on five wards providing end of life care. All patients we spoke with told us that staff were caring and compassionate. We were told "This is like my home, I cannot fault the care, they are all good, nurses and

End of life care

consultants". We observed good communication, and staff spoke very enthusiastically about the palliative care team and the advice and support they provided to both themselves and the patients.

We saw that a patient who was receiving end of life care was treated with dignity and respect. Staff told us that they had got to know family members well and involved them in decisions. Family members were able to visit at any time, and staff encouraged and supported this. We looked at this person's care plan and saw that information had been provided for staff to ensure that their end of life wishes were followed. Documentation by the palliative care team highlighted that this person should not be subjected to blood tests or cannulation, and pain relief requirements had been clearly documented.

We spoke with doctors carrying out ward rounds, and observed doctors speaking with patients. We saw that time was given to patients to allow them time to discuss their treatment and any worries and concerns. Doctors and nurses we spoke with told us they accessed the palliative care team regularly and they were aware of the fast-track pathway tool for rapidly deteriorating patients. We were given examples of when this had been used to ensure people were able to die at home if this was their wish. We also saw examples of patients who wished to stay in hospital or whose condition had deteriorated rapidly and staff had been able to provide appropriate end of life care on the ward. We saw that family and multidisciplinary team meetings had taken place, and saw documentation which showed that it had been the patient and their families wish that they remain on the ward. This meant that patient's preferred place of death had been considered and met whenever possible.

Care for patients and relatives

We visited the multi-faith room, bereavement services and mortuary, including the viewing area. A multi-faith room was accessible for staff, patients and visitors. We were unable to speak to the chaplain as he was away. However, people we spoke with who had accessed the multi-faith room told us it was "calm and peaceful". An ablutions room was situated next door for people to wash before prayers. Staff we spoke with on the wards visited, and those who worked for the bereavement service, told us the chaplain worked closely with the ward staff to provide spiritual support to any patient who wished to access the service.

We visited the bereavement service. This was available Monday to Friday and was staffed by one full-time and one part-time member of staff. Staff told us they received people's notes after they died, and they had a clear process to follow to ensure that documentation was completed. Family or next of kin then collected death certificates and any belongings from the bereavement service. Staff felt appropriately trained to offer support to people during their bereavement.

We visited the mortuary and spoke to staff. We saw that all areas were clean and well organised. Equipment was available to transport people to the mortuary in a dignified manner. This included a specialised bariatric trolley and lift if required. Staff were able to tell us how they met the needs of people with cultural or religious needs. One told us, "I always talk to friends or relatives about what they need, and we can ensure things are done in accordance with their wishes." Staff told us that they had access to the bereavement office at weekends and out of hours, and could complete documentation to ensure that death certificates were issued in a timely way for people whose religious needs required this.

We saw the viewing room where people could pay their last respects. This was a nicely decorated, calm and dignified area. Staff talked us through how they met family and next of kin at the main reception and walked with them to the viewing room. People were taken into a small lounge room where they could sit until they felt ready to enter the viewing room, staff would sit with them and prepare them for what to expect. Information and leaflets were available for people to take away. The viewing room was nicely decorated and felt calm and peaceful. People were given time and were able to talk with staff or spend time alone. Staff told us they arranged all viewing times and therefore they ensured that people had as much time as they needed.

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

Good 

End of life care services within the hospital were responsive to people's needs.

End of life care

There was a specialist palliative care register. On admission to hospital via A&E, patients on the register would be 'flagged up' and the palliative care team informed of the admission. The palliative care team prioritised their response and would either give information and advice to staff over the telephone or visit the patient if required.

We spoke with patients, relatives and staff. Staff were able to tell us how they responded to changes in people's condition. This included pathways and rapid discharges for people wishing to return home to die. The palliative care team also had close links to community services to enable care packages to be set up at short notice to enable people to return home if this was their wish. By working closely with community services to manage people's symptoms, this in turn led to fewer inappropriate hospital admissions. It was not always possible for patients to return home or be transferred to the local hospice. This could be due to a lack of beds or because people became too unwell. The palliative team told us that they monitored this and always aimed to meet people's needs whenever possible.

Patients and relatives told us that they felt they were given clear information about treatment options, and felt prepared for end of life care decisions.

During our visit to the mortuary we saw that facilities were sufficient to meet the needs of the hospital. An extension area had increased capacity and meant that the hospital was able to respond appropriately in an emergency situation or in times of increased capacity requirements.

Are end of life care services well-led?






Good 

The palliative care team was able to demonstrate to us that end of life care was being managed and run effectively despite recent changes to its structure. We saw that wards were providing a high standard of end of life care throughout the hospital. Staff spoke highly of the palliative care team, and staff ensured that patients received a good standard of care. We saw evidence of good leadership by senior staff on wards and staff being involved in changes and development.

We saw evidence of a multidisciplinary team approach to care, with teams working closely to ensure that end of life care needs had been met and people received appropriate end of life care.

The palliative care team had been monitoring direct and indirect patient contact, and told us referral numbers had increased as more ward staff and doctors had utilised the service. All patients were discussed at weekly meetings; these had been attended by members of the team and doctors and were an opportunity to discuss patients care needs, and to ensure that treatment remained appropriate. This demonstrated that the service was well led.

Outpatients

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

Information about the service

Outpatient services are provided at a number of locations throughout the trust. The main outpatient department is at Darent Valley Hospital. In addition to these, there are individual outpatient areas in the Diabetes Centre and the Maternity and the Children's Resource Centre (children's outpatients only). A wide range of outpatient services and therapies are provided by the trust. We visited the main outpatients department, the fracture clinic and oncology outpatients. We spoke with ten patients attending outpatient appointments in a range of clinics. To monitor waiting times we tracked three patients from the time they arrived at the department until their appointment took place. We spoke with the outpatient general manager, senior nursing staff, nurses, booking and administrative staff. We looked at the self-check-in system, and viewed how appointments were checked in by reception staff, and reviewed information given to us by the trust.

Summary of findings

The main outpatients department was a large area, with good access and seating for patients. Patients received effective treatment and information and felt happy with the care they received. The trust was monitoring appointment targets for waiting times and clinic start and finish times. It had sought the views of patients, and we saw that it had listened and responded to patient feedback by changing the layout of the department. Clinics were well managed and organised. When unavoidable delays occurred and clinics ran late, staff kept patients informed and provided them with information. Staff told us that they received training and supervision to enable them to provide effective care. All staff we spoke with told us that outpatients was a positive environment to work in.

Outpatients

Are outpatients services safe?

Good 

Environment

The outpatient department was large with appropriate seating and wheelchair access. All areas of the department were clean and well maintained. The reception area was large and welcoming, with good clear signage for patients. Antibacterial hand gel was available to staff and visitors. The main outpatients department was by the main entrance. Wheelchairs were available to assist patients with reduced mobility. We saw elderly and frail patients being assisted by porters and reception staff within the department.

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

Not sufficient evidence to rate 

We tracked patients attending clinic appointments to monitor waiting and clinic times. Booking and reception staff told us how the booking system worked. The computerised system meant that patients could be tracked from the moment they checked in at the department. It also logged when their appointment began and finished. In the fracture clinic we saw reception staff booking future appointments or discharging patients who were no longer required to attend. Reception staff told us the system was well organised and easy to use.

We saw that some patients chose to use the self-check-in service and others preferred to check in with reception staff. We talked with senior nursing staff about how individual clinics were organised and run. Staff told us they worked across a number of different clinics and found that the clinics ran smoothly. In the event of a problem with the automated booking system or screens, reception staff were able to book and arrange clinic appointments. Patients we spoke with told us that they found the system effective.

We were told that outpatient clinics often ran late. This could be caused by a change in consultant availability or

appointments taking longer than expected. During the morning of the inspection there were seven clinics running in the main outpatients department. We saw that two clinics were running late by 10am. We spoke with one patient whose appointment was running 30 minutes late. They told us that they had seen an announcement on the screens in the waiting area informing them of the delay and that a member of staff from the clinic had also spoken with them to apologise for the delay. Patients experiencing delays seemed satisfied that this was beyond anyone's control and was 'just one of those things'. Patients gave positive feedback about the general running of clinics and told us that staff were very helpful. Systems were in place to monitor delays, and clinic start and end times were checked daily. Senior staff told us that regular monitoring meant that they could identify which clinics had delays and look at ways to prevent this in future.

We spoke with reception staff, and they told us that sometimes patient medical records did not arrive at the clinic in time. Although this happened on an almost daily basis, this was identified at the beginning of a clinic, and notes could usually be located quickly. Effort was made to ensure that this did not impact on the patient but occasionally this could lead to a delay in appointments.

We visited the fracture clinic and saw that this was a very busy area throughout the day. Staff told us that the clinic ran smoothly, and patients spoken with were happy with the service provided. The fracture clinic was a smaller area than the main outpatients department. Despite being very busy patients were seen in a timely manner and there was adequate seating provided for patients and family.

Staffing

Staffing told us they felt that staffing levels within the main outpatients department were adequate. Senior staff told us that the ratio was 60% nursing assistants and 40% registered nurses. Not all clinics required nurse input; therefore this was adequate to meet the needs of patients during busy clinic times. All staff we spoke with told us that outpatients was a positive environment to work in. The department had recently taken over the phlebotomy service; staffing levels had been increased as waiting times had been long in phlebotomy. The employment of new staff had a positive impact on waiting times for this service.

Outpatients

Staff told us that they received training and supervision to enable them to provide effective care. All staff we spoke with told us that outpatients was a positive environment to work in.

Are outpatients services caring?

Good 

We saw that staff had completed self-assessment forms which focused on patient care. These had been used as part of their appraisal system to evaluate their interaction with patients. This was to improve the patient experience whilst attending the outpatients department.

Information about services available was provided in the outpatients department. Self-check-in systems were accessible in a number of different languages. We observed a patient who required assistance arrive at the department. Staff responded quickly and effectively to support this patient with their needs. We observed excellent communication throughout the department. Staff were seen to sit with patients to allow communication at eye level. Patients were given time to ask questions and staff, although busy, made time to assist people when needed.

The appointment system used a numbering system. Staff told us this was to ensure patients' privacy and dignity. After booking in, a patient's number would be called with verbal instructions about which zone patients needed to go to. We asked staff how this system worked for people who were hearing or visually impaired. Reception staff told us they put a note on the computer screen to alert staff in individual clinics if the patient required any specific help or assistance. Staff from the clinic would come to the waiting area to assist the patient rather than their number be called by the automated system. This meant that patients received appropriate care to meet their individual needs.

Patients told us that they received appropriate information before and after appointments. One patient told us they had chosen to attend their outpatient appointment at Dartford Hospital in preference to a hospital closer to where they lived.

Are outpatients services responsive to people's needs?

(for example, to feedback?)

Good 

Waiting times

The department had met 13-week targets for time of referral from GP to the start of treatment. Staffing levels had been improved, and evening clinics had taken place. This meant that patients received more choice regarding appointment times, and aided meeting appointment targets as there were longer clinic times. The trust had been monitoring clinic start and finish times, and looking at incident reports within the department to ensure that standards of safety, care and treatment had been maintained. We saw that a complaint had been received which related to a cancelled appointment in an outpatients clinic, due to a problem with equipment. Actions had been taken to help prevent this issue reoccurring, and reassurance given to the patient.

The introduction of text message appointment reminders for patients and longer clinic times had impacted positively on missed appointments. The trust was aware of the need to ensure that clinic waiting times were monitored, and it was working with an emphasis on the key 'values' and six Cs to improve the patient experience.

Patient transport

Patient transport services had changed in July 2013. This had led to problems with transport arrangements for patients, and caused missed appointments due to transport being cancelled at short notice or being unavailable. The trust had taken action, and through discussion with the provider and the local commissioning group changes had been made to the service. This had led to an improvement in the service, though this was still being monitored. This showed that the trust was responsive to issues impacting on patients. We observed excellent staff communication and interaction with patients when they arrived at the department, with assistance being offered to patients who required it. We spoke to staff in the fracture clinic who told us they received support and training around handling challenging behaviour.

Outpatients

Environment

The outpatient department had carried out patient surveys. Staff working in the department told us that the layout of the reception desks had recently been changed in response to patient feedback. The desks were now more open and patients could see and speak to reception staff easier. Patients told us that they preferred the new layout as it was more open and they could see reception staff more clearly. One patient said, "On coming through the door the view of the reception was excellent, open and friendly – much improved."

Patient surveys

A member of nursing staff had recently devised a survey which looked at nursing older people in an outpatients department. This had been presented to the Board. And a further survey was to take place looking at a broader spectrum of elderly patients.

A vast array of information was displayed within the department. Information was also displayed regarding quality within the department. This included the dementia buddy scheme, the department's values, and the 'six Cs' for nursing staff: communication, care, courage, compassion, commitment and competency. The department had a named dignity champion who had carried out work within the department in the form of a patient survey to improve patient experience.

Information was available in different formats. Information was also available on the hospital's website in different languages. The self-check-in system could be accessed in seven languages and support and assistance was provided by reception staff when needed.

Are outpatients services well-led?

Good 

Leadership

Senior staff told us they were involved in negotiating with consultants regarding clinic times, and they felt listened to and involved in the day-to-day running of, and improvements to, the service. Staff felt supported by their fellow workers, and peers and told us that the staffing structure allowed for openness and non-hierarchical discussion. The department frequently had student nurses and trainee paramedics on placement as part of their training. The department had received excellent placement feedback from the university.

The trust had a clear complaints system, and all staff we spoke with understood the importance of responding to complaints and could give a clear explanation about how complaints would be escalated. Information about complaints received by the trust showed actions and learning had been included in the response to the complainant.

We saw information displayed in the department informing patients of the quality review, and saw evidence that patient feedback had been listened to with regards to the layout of the department.

Good practice and areas for improvement

Areas of good practice

- An integrated discharge team had been introduced to help with the safe, effective and timely discharge of patients.
- The number of midwives had been increased and changes had been made to the environment in the maternity unit to meet the needs of women and their partners using the service.
- The hospital's bed management meetings were multidisciplinary and included executive team members and ward sisters to ensure trust-wide understanding and involvement in the decision-making process.
- End of life care provided at the hospital was safe, effective, caring, responsive and well led.
- There was a positive approach to managing the needs of people with dementia. Consideration had been given to good practice guidelines and recommendations. On the ward where most people with dementia were cared for, environmental changes had been made. There was a Dementia Buddies scheme in place, supported by volunteers.
- A code of conduct for nursing assistants had been developed and launched in the trust.
- Patients should be treated with dignity and respect at all times, particularly in the area of the operating department where patients are received.
- Patients' privacy and right to confidentiality should be respected at all times. Staff need to be more careful in making sure that confidential information is not seen and heard by others.
- The trust must ensure that at all times patients are cared for in a safe environment that is designed to meet their needs. It needs to consider the use and management of escalation beds in response to challenges with the higher-than-average occupancy levels, which, in turn, is impacting on the trust's use of mixed sex accommodation.
- The trust should take action to ensure that good practice guidance is being considered and used in all areas of the trust, particularly A&E.
- The trust should ensure that children's pain relief is administered and the effectiveness monitored in line with good practice guidelines.
- The trust should review the plans with the local healthcare community to ensure that patients needing emergency care are managed safely and effectively.
- The trust should develop an agreed vision with identified timelines and projected outcomes and impacts.

Areas in need of improvement

Action the hospital **MUST** take to improve

- The trust must ensure that the required number of staff with the correct skills are employed and managed shift by shift, to demonstrate that there are sufficient staff to meet people's needs.

Action the hospital **SHOULD** take to improve

- The trust needs to ensure that learning from the reporting of incidents is cascaded and that any changes to practice required following a serious incident are implemented in a timely manner.

Action the hospital **COULD** take to improve

- While the trust had a relatively high compliance with attendance at its mandatory training, the actual attendance levels were generally below the trust's desired level. Its own monitoring system was not always ensuring attendance. The trust could review the actions taken for non-attendance at mandatory training.
- The trust needs to ensure that nursing staff are not disturbed when administering medication.
- The trust could ensure that all staff have an awareness of the Mental Capacity Act.
- The trust needs to ensure that it follows good practice with regards to the consenting of patients prior to surgical procedures.

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Health and Social Care Act 2008</p> <p>(Regulated Activities) Regulations 2010 Regulation 22 Staffing.</p> <p>In order to safeguard the health, safety and welfare of service users, the registered person must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.</p> <p>There were not enough qualified, skilled and experienced staff in the accident and emergency department to meet people's needs. This was because of the high reliance on locum middle grade medical staff, insufficient numbers of nurses qualified in the care of children and vacant consultant posts.</p>
Regulated activity	Regulation
Diagnostic and screening procedures	<p>Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, Regulation 10 Assessing and monitoring the quality of service</p> <p>Provision</p> <p>The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to –</p> <p>a) regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this Part of these Regulations; and</p>

Compliance actions

(b) identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity.

(2) For the purposes of paragraph (1),

(c) where necessary, make changes to the treatment or care provided in order to reflect information, of which it is reasonable to expect that a

registered person should be aware, relating to –

(i) the analysis of incidents that resulted in, or had the potential to result in, harm to a service user.

The trust had a system in place for the reporting of accidents and incidents and for the investigation of those events considered to be a serious incident. The learning outcomes from the reporting of incidents were not consistently being shared. People were being placed at risk by it taking up to a year to implement changes to practice from the learning following a serious incident. While audits were being conducted the learning from these were not consistently being shared. The trust had no current clear vision with identified time lines and projected outcomes and impacts.

Regulated activity

Surgical procedures

Regulation

Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, Regulation 10 Assessing and monitoring the quality of service

Provision

The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to –

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Regulated activity

Diagnostic and screening procedures

Regulation

Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, Regulation 15 Safety and suitability of premises

15. (1) The registered person must ensure that service users and others having access to premises where a regulated activity is carried on are protected against the risks associated with unsafe or unsuitable

premises, by means of –

suitable design and layout

Patients' safety was being affected by the trust's high bed occupancy and the use of additional beds in areas not designed to be used for patient care. Patients were also being placed at risk in the accident and emergency

This section is primarily information for the provider

Compliance actions

department because of the lack of clear directions for patients to follow to access the adult triage facilities in the minors area of the department. The facilities in the intensive care unit were not suitable to meet the needs of patients no longer requiring intensive care.

Regulated activity

Regulation

Surgical procedures

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Regulated activity

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Regulated activity

Diagnostic and screening procedures

Regulation

Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, Regulation 17 Respecting and involving service users.

17. (1) The registered person must, so far as reasonably practicable,

make suitable arrangements to ensure –

(a) the dignity, privacy and independence of service users; and

(2) For the purposes of paragraph (1), the registered person must –

(a) treat service users with consideration and respect.

In some areas of the trust patients were being cared for on mixed sex wards and in some they had to share bathroom facilities with members of the opposite sex. People's privacy and dignity were not always respected: personal information was on display in public areas and discussions took place in open areas where they could be overheard. The area where people were received in the operating theatre department was open, compromising people's dignity, and they were not always treated in a respectful way. Those people no longer in need of intensive care but not able to move to a general ward also had their dignity affected by the facilities available on the unit.

Compliance actions

Regulated activity	Regulation
Surgical procedures	<p>Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, Regulation 17 Respecting and involving service users.</p> <p>17. (1) The registered person must, so far as reasonably practicable,</p> <p>make suitable arrangements to ensure –</p> <p>(a) the dignity, privacy and independence of service users; and</p> <p>(2) For the purposes of paragraph (1), the registered person must –</p> <p>(a) treat service users with consideration and respect.</p> <p>In some areas of the trust patients were being cared for on mixed sex wards and in some they had to share bathroom facilities with members of the opposite sex. People's privacy and dignity were not always respected: personal information was on display in public areas and discussions took place in open areas where they could be overheard. The area where people were received in the operating theatre department was open, compromising people's dignity, and they were not always treated in a respectful way. Those people no longer in need of intensive care but not able to move to a general ward also had their dignity affected by the facilities available on the unit.</p>
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Compliance actions

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Regulated activity

Diagnostic and screening procedures

Regulation

Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, Regulation 9 Care and welfare of service users

(1) The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of –

(a) the carrying out of an assessment of the needs of the service user;

and

(b) the planning and delivery of care and, where appropriate, treatment in such a way as to –

(i) meet the service user's individual needs,

(iii) reflect, where appropriate, published research evidence and guidance issued by the appropriate professional and expert bodies.

In the accident and emergency department pain relief was being well managed and assessed for adults but not for children, meaning that effectiveness was not being

Compliance actions

monitored in line with national guidelines. Guidelines in some areas had been reviewed and updated. However in accident and emergency there was guidance that was out of date or not the most current version.

Regulated activity

Regulation

Surgical procedures

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Compliance actions

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