Dorset Healthcare University NHS Foundation Trust

RDY

Urgent care services

Quality Report

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Date of inspection visit: 23-26 June and unannounced 9 July 2015
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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RDYX8	WEYMOUTH COMMUNITY HOSPITAL		
RDYY6	PORTLAND HOSPITAL		
RDYX9	WESTMINSTER MEMORIAL HOSPITAL, SHAFTESBURY		
RDYY4	YEATMAN HOSPITAL, SHERBORNE		
RDYEJ	BRIDPORT COMMUNITY HOSPITAL		
RDYFF	SWANAGE COMMUNITY HOSPITAL		
RDYX4	BLANDFORD COMMUNITY HOSPITAL		
RDYFE	VICTORIA HOSPITAL, WIMBORNE		

This report describes our judgement of the quality of care provided within this core service by Dorset Healthcare University NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Dorset Healthcare University NHS Foundation Trust and these are brought together to inform our overall judgement of Dorset Healthcare University NHS Foundation Trust

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

We rated caring as good but found safety inadequate and the effectiveness, responsiveness and leadership of urgent care services/minor injury units required improvement.

- The quality of clinical leadership needed to improve in most of the minor injury units (MIU), and there was insufficient leadership of urgent care services across the trust. We found visible and positive clinical leadership at Blandford and Swanage MIUs which resulted in a locally well led and organised service. However, at Weymouth, Portland and Bridport MIUs we found some serious issues.
- The trust governance frameworks did not always operate effectively for MIUs. There were insufficient processes for proactively identifying, assessing and managing risks and seeking staff views. There was insufficient auditing of quality or learning across the service.
- There was no clearly defined system for ensuring timely clinical assessment of patients arriving at the MIUs. This meant the service was not assessing and responding to potential risks, and patients could be waiting for some time without clinical assessment, when possibly needing urgent or more acute care and treatment. This was not in line with the trust's service operational policy or national guidance.
- There were staff shortages across the service and on occasions agency staff were lone working without adequate support or induction. There was variation in the experience and skills of staff employed in the units and the required qualifications and competency checks were unclear and inconsistent, particularly for lone workers.
- There was an electronic incident reporting system in place, and some evidence of learning from incidents, but the process was not clearly understood or used by staff at all units.
- Not all staff were up to date with safeguarding training and some staff did not know about, or respond appropriately to, the child protection flags on the electronic patient records system.
- Resuscitation equipment was not always regularly checked or fit for use and not all staff had completed updated training on intermediate life support. Maintenance and testing of some pieces of electrical equipment was out of date.
- Medicines were well managed in many units, and there was monitoring of storage of refrigerated medicines. However, the service had identified insufficient pharmacy support and some medicines were not stored securely. Although recently updated on electronic systems, some staff were using out of date patient group directions to administer medicines to patients.
- We observed staff following infection control policies and procedures, but there was little evidence of auditing of the environment and staff practice to ensure this was implemented consistently.
- We found some out of date NICE guidance but some updated treatment protocols were available for use in some of the MIUs. We were told of up to date guidelines held electronically, but these were not always accessible or used by staff, particularly agency staff. There was little auditing of adherence to guidance or monitoring of patient outcomes.
- There were inconsistencies in clinical supervision and continuous professional development with some staff receiving more support and funding than others, depending on their location.
- The environments of some minor injury units were cramped and reception areas compromised privacy and confidentiality. The poor signage to some units potentially led to patients attending acute hospital when not needed.
- MIUs achieved the government's four hour waiting targets but they did not provide clinical assessments on patients arriving in the department within the 15 minute timescale. Some MIUs had to close when there was insufficient staff to provide the service, and there was little or no xray services at some of the locations.
- There was limited understanding of, or adjustments for, the needs of people with a learning disability and staff had not attended dementia training.

Summary of findings

- MIU staff had a variety of managers, some had no specific knowledge or experience in emergency nursing, and accountabilities were sometimes unclear to staff. Although staff enjoyed their jobs in MIU, some felt isolated and undervalued by the trust.
- The MIU staff were unclear about the vision and strategy for the service. They were aware of a clinical services review being undertaken across Dorset, but did not feel informed or consulted.
- The service specification was outdated and not being followed as it did not reflect the current service provided by the MIUs.
- There was a clear process for patients to raise complaints and some, but not always, evidence of learning and improvement in the service as a result of complaints.
- There were good links with acute services and appropriate referrals. There were examples of close working with GPs but some inconsistencies.
- Verbal consent was obtained for care and treatment and this was sometimes recorded in patient records. Staff demonstrated understanding of the Mental Capacity Act (2005).
- Nurses were caring and compassionate across all MIUs we visited. Patients spoke highly about the staff and were involved in decisions about their care and treatment.

Summary of findings

Background to the service

Dorset Healthcare University NHS Foundation Trust provided urgent care services through eight minor injury units (MIUs) across Dorset. The units were based at the community hospitals, serving market towns and rural areas across all areas of Dorset.

The MIUs provided a service for patients with minor health problems and injuries from accidents that were not serious and not likely to be life threatening. The MIUs were nurse led.

There were between 9,100 and 12,719 attendances per quarter at MIUs across Dorset in the year ending 31 March 2015 with a higher number over the summer months. There were 12,719 attendances from July – September 2015.

All eight minor injury units had a variety of opening hours and some were open weekends and bank holidays. The eight MIU's we visited were:

SWANAGE - Queens Road, Swanage, BH19 2ES. (08:00-20:00)

PORTLAND - Castle Road, Castletown, Portland, DT5 1AX. (10:00-18:00)

WEYMOUTH - Melcombe Avenue, Weymouth. DT4 7TB. (08:00-22:00)

BRIDPORT – Hospital Lane, North Allington, Bridport. DT6 5DR. (09:00-18:00)

SHERBORNE – Hospital Lane, Sherborne. DT9 3JU (09:00-18:00)

SHAFTESBURY – Abbey Walk, Shaftesbury, SP7 8BD. (09:00-18:00)

BLANDFORD – Milldown Road, Blandford Forum. DT11 7DD. Tel: (09:00-18:00)

WIMBORNE - Victoria Road, Wimborne BH21 1ER. (08:30-16:00)

Our inspection team

Our inspection team was led by:

Chair: Neil Carr OBE, Chief Executive of South Staffordshire and Shropshire Healthcare NHS Foundation Trust.

Head of Hospital Inspection: Karen Wilson-Bennett - Head of Inspection for Mental Health, Learning Disabilities and Substance Misuse, Care Quality Commission.

The MIU inspection team included three CQC inspectors, a pharmacist inspector and two specialist advisers who were senior nurses in emergency and urgent care.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Summary of findings

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out announced visits to all MIUs between 23 and 26 June 2015. During the visits we spoke with a range of staff who worked within the service, such as emergency nurse practitioners, nurses, healthcare assistants, receptionists and senior managers. We talked with people who use services and received feedback on comment cards. We observed how people were being cared for and talked with carers and/or family members and reviewed records of people who use services. We carried out unannounced visits to Portland, Weymouth and Shaftesbury MIUs on 9 July 2015.

During the visits we reviewed 26 patient records across the MIUs, spoke with 20 staff and four managers and spoke directly with10 patients and four relatives.

What people who use the provider say

The Minor Injury Units (MIUs) were highly valued by their local communities. One patient described Portland MIU as 'an important service for the island of Portland'.

The local population as well as holiday makers, were pleased with the service they received from the MIUs.

The Friends and Family Test results were positive, with patients responding that they would recommend the service.

Patients at Blandford and Swanage MIUs spoke directly to the inspection team to say what good services they had received and how caring the staff were.

At Bridport MIU, a patient told the inspection team that their family had always received caring and competent treatment quickly. This meant they avoided going to the acute trust's emergency department which resulted in waiting hours to be seen.

Some patients commented on the 'speedy service'. Others were happy with the service but concerned they had to wait before being seen by a clinician.

Good practice

- The medicines refrigerator temperature records were displayed visually as a graph so it could be clearly identified if a reading was outside normal limits (area coloured red). There were clear instructions for staff to follow in the case of temperature variation.

Areas for improvement

Action the provider MUST or SHOULD take to improve

The trust MUST ensure that:

- Operational policy and service specification for minor injury units are clear, meet the needs of patients and are communicated to staff.
- The leadership of the service is strengthened at both individual minor injury unit level and trust wide.
- A formal system is implemented that ensures all patients attending a minor injury unit receive a timely clinical assessment in line with national guidance.
- There is robust monitoring of safety and quality, risks are identified and timely actions taken to manage risks in the service.
- Governance arrangements are robust, including management of the risk register.
- Patients confidentiality and privacy is maintained when booking into MIU reception and disclosing their reason for attendance.

Summary of findings

- There are, at all times, sufficient numbers of adequately experienced and skilled staff to ensure safe, effective and responsive care and treatment.
- Emergency equipment is fit for purpose and available in all areas at all times.
- All staff are trained in basic life support to deal with emergency situations.
- All staff are up to date with safeguarding training, know how to identify and report concerns and respond appropriately to child protection flags.
- All staff working in MIU have access to, and follow, clinical guidelines and treatment protocols that are in line with NICE guidelines and latest evidence based guidance.
- Equipment servicing and checks, including PAT testing, equipment maintenance and calibration are carried out regularly and a record kept that they are safe for use.

The trust Should ensure that:

- Service strategies are developed with consultation with staff, patients and the public, and they are clear and communicated effectively.
- Equipment and medicines required in an emergency are tamper evident and standardised.
- All staff are supported and encouraged to report and learn from incidents and complaints consistently to support continuous improvement in service quality.
- Lone working arrangements for nurses, and the availability of healthcare assistants and receptionists for MIUs when they are open.
- All staff working in MIU have access to protocols, trust policies and procedures and all other trust information on the intranet.
- The Patient Group Directions used in MIU are signed by staff, and within date.
- Staff receive clinical supervision and appraisals by a senior nurse who understands their job role.
- Nurses have access to specialist clinical advice and training to support them to deliver latest evidence based practice in MIUs across the trust.
- There is a visible clinical lead nurse on duty for all MIUs on every shift.
- MIUs and adjacent departments, such as X-ray departments are easily accessible.
- There is clearer signposting of the MIUs in towns, so patients know where to attend with minor injuries. Also clearer signage at the hospital's main entrance or in the car park, with opening times advertised.

Dorset Healthcare University NHS Foundation Trust

Urgent care services

Detailed findings from this inspection

Inadequate

Are services safe?

By safe, we mean that people are protected from abuse

Summary

There was no clearly defined system in operation for ensuring timely clinical assessment of patients arriving at the Minor Injury Units (MIUs). This meant the service was not assessing and responding to potential risks, and patients could be waiting for some time without clinical assessment when possibly needing urgent or more acute care and treatment. This was not in line with the trust's service operational policy or national guidance.

There were staff shortages across the service and on occasions agency staff were lone working without adequate support or induction.

There was an electronic incident reporting system in place, and some evidence of learning from incidents, but the process was not clearly understood or used by all staff.

Not all staff were up to date with safeguarding training and some staff did not know about, or respond appropriately to, the child protection flags on the electronic patient records system.

Resuscitation equipment was not always regularly checked or fit for use and not all staff had completed updated training on intermediate life support.

Maintenance and testing of some pieces of electrical equipment was out of date.

Medicines were well managed in many units, and there was monitoring of storage of refrigerated medicines. However the service had identified insufficient pharmacy support and some medicines were not stored securely. Although recently updated on electronic systems, some staff were using out of date patient group directions to administer medicines to patients.

We observed staff following infection control policies and procedures, but there was little evidence of auditing of the environment and staff practice to ensure this was implemented consistently.

There were plans in place to respond to seasonal demand and major incidents, and this was seen at Weymouth MIU.

We found that Blandford and Swanage MIUs were more efficicient in providing a safer environment and reducing risks to the patients that attended. This was due to good local clinical leadership.

Detailed findings

Inadequate

Are services safe?

Safety performance

- Between 24 June 2014 and 23 June 2015 a total of 63 incidents were reported for Minor Injury Units across the trust. All but one were classified as low or no harm, two were near misses where harm was prevented. There were no serious incidents requiring investigation. This high proportion of incident reports of no or low harm is indicative of a safe culture for reporting incidents.
- The MIUs did not use any other safety monitoring tools.

Incident reporting, learning and improvement

- The incidents were reported electronically and there was shared learning amongst the MIUs. A nurse in charge at Swanage MIU gave us an example of two incidents that occurred at other MIUs where a patient diagnosis was missed. Although this related to specific clinicians, all other MIUs were made aware of this situation so that nurses could ensure thorough patient assessments were completed and skills kept up to date to avoid a recurrence.
- We found that some staff we spoke with at various MIUs, were unsure how to report incidents on the electronic system and could not give us examples on what they would report as an incident. We did however speak with staff at Swanage, Wimborne and Bridport who were familiar with the process. Nurses and healthcare assistants at these units said they received feedback from the modern matron following serious incidents reported.
- At the unannounced inspection, the locality manager for Weymouth and Portland MIU gave us an action plan on how she aimed to improve incident reporting.
- Nurses had a good understanding of 'duty of candour' and explained the need to be open and transparent with patients when things go wrong. However, some were not clear on the legislation behind it.

Safeguarding

- MIU staff were required to attend level 2 adult safeguarding training and level 3 child safeguarding training. Trust records for May 2015 showed that not all staff at some MIUs were up to date with training.
- Completed adult safeguarding training updates were67% at Wimborne and 60% at Weymouth and Portland.. At Portland and Weymouth 66.7% had attended child safeguarding level 2 training and 50% at level 3. At Sherborne 100% had attended child safeguarding level 2 but there was no record of attendance at level 3.
- During the inspection, we saw a child attending Weymouth MIU had an alert, in the form of a flag on their patient electronic record. This was a safeguarding flag to alert staff treating the child that concerns were already raised and the child was vulnerable. Despite this flag being present on the screen as a safeguarding concern, the child was not seen promptly and it was not raised to the nurse on duty. The child was not assessed for two hours. This incident was raised to the service and at trust level at the time of the inspection so action could be taken to avoid a recurrence.
- We observed a child being treated at Wimborne MIU who had many cuts and bruises all over both legs, but the nurse did not ask why. They treated the child for the injury they attended with, but failed to notice the child's hurt legs. A holistic assessment of the child was not carried out by the nurse who focused on the presenting complaint.
- Most staff had safeguarding awareness and could describe their responsibilities. However, at Sherborne MIU, nurses told us they did not report safeguarding concerns or make referrals. In discussion they did not recognise safeguarding concerns, or felt it was not necessary to report. The staff we spoke with were not aware of the child protection flagging system.
- At Swanage MIU flow charts were on display in the office, showing the referral process for both child and adult safeguarding concerns. Both the nurses and healthcare assistants knew where to locate the information and the process to follow.
- Staff at Swanage MIU were able to access the child protection register electronically, and children on the register were flagged so staff were aware. A nurse at Bridport demonstrated the process followed when a child arrived in MIU who was on the risk register. They showed us the alert system, and the liaison with social services. Staff at Blandford were also aware of the flagging system.
- Nurses completed a detailed form for all children attending MIU. This included information such as their

history, presentation, unexplained injuries, observation of interaction with their parent or carer, and who attended the MIU with them. This form was then sent to the social work team.
- At Bridport MIU, a children's nurse had recently been appointed to take the lead on safeguarding.
- Staff had little awareness or understanding on how to deal with domestic violence when we raised this at Sherborne MIU. No information on domestic violence was available or on display in the waiting rooms but some information was seen in Swanage and Bridport public toilets.

Medicines

- Medicines were well managed in many units, but we found some inconsistencies across MIUs. We found some medicines were not stored securely. They were left out on surfaces that could be accessed by patients, and not locked away. We found a plaster remover at Bridport MIU on a trolley that expired in January 2014; it was not locked away and was accessible to patients if the nurse was called away from the treatment room.
- There was an anaphylaxis kit available at Bridport MIU but it was on a shelf with other medications that were not locked in a cupboard. At Blandford we found aspirin and a Glyceryl Trinitrate spray that was in a drawer and not in a locked cupboard.
- At Shaftesbury MIU, the wrong valve had been fitted on an Entonox gas cylinder.
- Some, but not all nurses were independent prescribers. FP10 prescription pads were locked away appropriately and a tracking system was in place.
- The Bridport unit's copies of the British National Formulary reference books were not the current version available. The BNF for children was dated July 2013, and the standard BNF was dated September 2013. There was however, internet access to information about medicines.
- There were inconsistencies with the patient group directions (PGDs) in use in the MIUs. PGDs are the formal arrangements for nurses to administer medicines to their patients during treatment that does not require a prescription. The PGDs on the trust intranet were in date, but these were not being used in all the MIUs.
- Blandford, Shaftesbury and Sherborne displayed in-date PGDs that were appropriately signed and updated. Some MIUs such as Swanage and Wimborne either had only some PGDs in-date, or none at all. At some sites, such as Weymouth, Portland and Bridport we found all PGDs were out of date, some dated 2011, and staff had not signed current revised versions that were available online.
- At the unannounced inspection, the Weymouth and Portland locality manager informed us that new and revised PGDs were to be printed and they would be accessible and signed by nursing staff in both MIUs. We were told the PGDs were updated and placed on the trust intranet the week before the inspection, but this was not communicated or acted upon by the clinical leads.
- At Sherborne we found intravenous fluid bags on the resuscitation trolley that had been written on in pen, highlighting their contents. This was unnecessary and could cause confusion or misreading of the contents in a hurry.
- The MIUs had no controlled drugs in stock and the registers were up to date, with no expired drugs in the cupboards. The medications were checked and recorded appropriately.
- Medication fridges were checked with dates and signatures present. Some sites such as Shaftesbury MIU had separate specimen and medication fridges. The medicines refrigerator temperature records at Portland were displayed visually as a graph so it could be clearly identified if a reading was outside normal limits (area coloured red). There were clear instructions for staff to follow if there was a temperature variation. This was important as some medicines could become ineffective if not stored at a cold temperature.
- The lack of pharmacy support to the MIUs had been identified on the trust wide risk register with action target dates set for June and August 2015, as well as April 2016. However we were unsure what actions had been taken to mitigate risks.

Environment and equipment

- We found portable appliance testing equipment calibration and servicing was out of date at most of the MIUs. This included ECG machine, blood pressure monitor, oxygen monitors, nebulisers, ophthalmoscope, plaster saw and slit lamp, at Swanage and Bridport MIUs. At Wimborne and Blandford MIUs we saw equipment had been tested and was in date.
- All units had resuscitation trolleys. At Swanage they were well stocked and laid out. However, some daily

checks were not carried out at Bridport and Weymouth MIUs and there were missing signatures seen on the records. Sherborne's trolley contained unneeded items, so was overfull.

- Much of the resuscitation equipment seen on the trolleys did not have expiry dates on them. We found no standardised trolleys in the trust, and each site had a different trolley with different equipment. Some were the newer metal versions, and we saw some at Sherborne and Shaftesbury MIUs that were wooden and older style without lockable drawers. The impact of having non-standardised trolleys meant that staff working across the units, as well as agency or bank nurses would not be familiar with different types of equipment and this could cause a delay in providing emergency care in a hurry.
- The resuscitation room at Shaftesbury MIU was cluttered with excess equipment in the room. This could impede or delay access to a patient in an emergency. At Wimborne MIU, the trolley for medicines and equipment required in an emergency was not tamper evident. At Portland the oxygen cylinder in the emergency grab bag had expired in April 2012.
- All waiting rooms were clean and tidy, and most of them had water coolers for patients to drink. Some contained vending machines instead of water coolers, such as Sherborne MIU.
- The waiting rooms contained modern chairs, but they did not accommodate bariatric and different height patients.
- Most reception desks contained panic alarms, and CCTV cameras were in use so that nurses could monitor the waiting room from the treatment areas. This meant that if a sick patient arrived while the reception was unmanned, nurses could attend to them quickly. Nurses could also see how many patients were waiting and if they needed to go into the waiting room to prioritise care. Panic alarms and emergency call bells were also available in all MIU treatment areas for nurses to summon help if needed, but we found some personal alarms did not have a battery. Some MIUs had allocated security staff but some had the general hospital porter that provided security between set times.
- Some MIUs shared a sluice with the neighbouring ward or department which made the room cluttered. Store rooms were also shared.
- Reception areas were often shared with other departments such as outpatients, day surgery or the main hospital reception.
- Treatment rooms were generally well stocked. They were often shared by other departments to run clinics throughout the day. Shaftesbury and Sherborne MIUs held leg ulcer clinics, sexual health clinics and mental health community appointments.
- Some MIUs were locked by a swipe card mechanism, but others were open for the general public to walk into clinical areas, although past a receptionist. This was evident at Shaftesbury and Swanage MIU.
- At Wimborne MIU we found a leaking sink in the visitor's toilet which left water on the floor and was a slip hazard. We also saw a leaking sink in the sluice at Shaftesbury MIU.
- We saw an equipment cleaning log at Wimborne MIU for June 2015 that showed when electro-biomedical engineering checks were due.
- The restricted access to the small treatment rooms and staff office at Wimborne MIU were on the risk register with an action target date for June 2015.
- Staff at Swanage gave us examples of two issues that they knew had been placed on the risk register but were now resolved. The first was related to a computer server than generated a lot of heat in the office that made working in there uncomfortable for the staff. This was resolved when it was relocated elsewhere. Secondly, patient treatment trolleys were too high, and they were replaced for lower ones that accommodated shorter patients.

Quality of records

- Records were kept electronically, and staff accessed the computer data bases through individual smart cards which were password protected. Staff at Swanage MIU were observed walking away from their computers in an unlocked office, without locking the screen or removing their smart cards.
- At Blandford MIU, patient information charts were available to staff in a filing cabinet that was labelled and organised. An audit in June 2015 identified records were completed correctly.
- At Swanage, a healthcare assistant made entries in a patient's notes on their examination findings and treatment which were not checked or countersigned by a registered nurse. The nurse had assessed the patient but did not document this in the patient records. We

raised concerns about the accountability of the nurse having delegated this task to the healthcare assistant and not documenting their own assessment and treatment plan that the healthcare assistant followed. The nurse realised the error, and was pro-active in resolving this issue. They obtained a job description for the healthcare assistant which clearly identified what assessment and treatment procedures they could carry out under supervision of the registered nurse. They requested changes to be made to the electronic record system to prompt registered nurses to authorise and countersign the activity of healthcare assistants. They also emailed the leads at the other MIUs to make them aware of the issue.

- At Weymouth MIU a healthcare assistant was seen putting hand written patient notes in the confidential waste bin. The patient's clinical observations and presenting complaint were listed on this sheet, and they had not transcribed this information onto the electronic patient records. The information was verbally handed over to the nurse but the original paper document was not kept or transcribed. At unannounced inspection we confirmed this was not MIU policy and practice.
- We reviewed patient electronic records across the MIUs for a range of patient conditions and outcomes. All records were detailed and appropriately completed. Information included if the patient decided to attend MIU themselves or by whom they had been advised to attend. Also their past and present medical history, presenting signs and symptoms and how it was affecting the patient, the examination, diagnosis and treatment given to the patient as well as the advice given to them on discharge.

Cleanliness, infection control and hygiene

- We observed a nurse at Blandford MIU not washing their hands and putting on non-sterile gloves before dressing a patient's wound. However, we observed good hand washing at all other MIUs. Hand washing facilities were available and notices were on display advising nurses, patients and visitors to wash their hands. Hand gel dispensers were also available.
- We observed nurses working 'bare below the elbow' at Bridport and Swanage MIUs which meant no watches, sleeves or jewellery were worn whilst providing patient care. However, a nurse at Shaftesbury MIU was observed wearing false nails.
- Staff had access to personal protective equipment such as gloves and aprons. Although we saw staff using gloves for dressing changes, they did not use them at other times.
- Clinical waste was managed safely but we observed the wrong waste bag had been placed in the wrong bin at Bridport MIU. This meant the contents of the bag may not have gone to the appropriate place for disposal. The sharps bins we saw were managed safely and labelled correctly.
- A healthcare assistant at Swanage MIU told us they had attended mandatory infection control training and showed us computerised records to confirm their training was within date.
- Trust records for May 2015 identified all staff had completed infection control training across all MIUs, other than Bridport where 75% staff had completed this training.
- All areas of the MIUs including treatment rooms, waiting rooms and offices were visibly clean and dust free, and cleaning schedules were on display. Some cleaning checklists were not fully completed, for example at Shaftesbury, but at Blandford and Sherborne they were. Some were done daily and some weekly. No indication was given on the cleaning schedules of the cleaning products to be used in certain areas or for specific equipment except for Wimborne MIU.
- Equipment was generally clean apart from Bridport where we saw a dirty blood pressure monitor. Equipment at Swanage and Bridport did not have stickers to confirm they were clean and ready for use. Stickers were in use at other sites, stating equipment had been cleaned with the time and date written on them. Cleaning wipes were available and used to wipe down patient treatment trolleys and chairs after use at Blandford.
- Some units had old wooden resuscitation trolleys, one was covered by an old green surgical drape, which was not necessary and was collecting dust.
- Privacy curtains between cubicles were cleaned and changed regularly. Dates of cleaning were detailed on the curtains.
- A cleaning and environmental audit had been completed at Blandford MIU, scoring 98%, but audits were not seen at the other sites.
- We saw undated records of hand hygiene audits at Blandford, Swanage and Sherborne, scoring as 100%. Audits were not provided for other sites.

Inadequate

Are services safe?

Mandatory training

- Subjects covered included basic life support, infection control, moving and handling, fire safety, information governance, conflict resolution and safeguarding children and adults.
- Registered nurses also completed intermediate life support and paediatric life support training on a yearly basis.
- The trust target was for 85% compliance with mandatory training. There was 85% overall compliance across all MIUs on the 25 June 2015, but not all had achieved this. Blandford, Bridport, Shaftesbury, Wimborne and Sherborne MIUs were 100% complaint in mandatory training. Weymouth and Portland were 77% and Swanage MIU was 75%.
- All training was logged on the intranet and staff as well as managers could track compliance. Most training was provided as e-learning, but it was not as popular with staff as no protected time was given to complete this.
- We were told Basic Life support training used to be e-Learning but was now a half-day session in a group of four.

Assessing and responding to patient risk

- Patients did not receive clinical assessment as recommended by the College of Emergency Medicine, and as stated in the trust's MIU service specification. National guidelines advise that, all ambulance and all head injury attendees at an MIU were assessed by a qualified, registered professional within 15 minutes of arrival. There were no processes in place to ensure this took place.
- Many patients presenting at the MIUs were not assessed by a registered nurse to identify any risks and their suitability to wait for treatment. This was a particular concern when a nurse was lone working and busy tending to a patient in the treatment room. Patients arriving in the MIUs were left waiting for varying lengths of time without clinical assessment by a nurse, which meant poorly patients could be left waiting with deteriorating health.
- In some units initial triage was undertaken by a healthcare assistant, who had attended an 'in house' assessment course. At the unannounced inspection we found a healthcare assistant undertaking the triage role who had not attended this training..
- Some reception staff had been trained on how to flag up an urgent patient to the nurse. The nurses told us they would see the patient as soon as possible if a receptionist called them. This was observed at Swanage MIU where the receptionist immediately flagged a patient with a head injury to the nurse on duty, who took appropriate action. Bridport MIU had a similar system, and staff confirmed they would interrupt a nurse's consultation if a poorly patient attended in the waiting room. However this was not consistent across all MIU sites, as there were not always reception staff on duty and there was not a trust wide process or training for 'flagging' concerns.
- We found patients waiting in Weymouth MIU had an average wait of over an hour before they were assessed by a nurse. One patient attending with a hand and head injury arrived at 11:57 and was assessed at 13:10. They were assessed by a healthcare assistant where their blood pressure and pulse rate were taken. Patient 2 attended with a hand injury, arriving at 11:43 and was seen by the healthcare assistant at 12:50. Patient 3 waited 1 hour and 40 minutes and was not triaged and patient 4 waited for 2 hours to be seen. This patient had right sided chest pain and had been vomiting. No assessment or clinical observations were carried out, and no analgesia was offered. We were told by the patient and a relative, that another patient had given pain relief to this patient while they were waiting. These concerns were raised to the trust management at the time of the inspection.
- At the unannounced inspection, a locality manager told us they were reviewing the lack of triage at Weymouth MIU and had developed an initial action plan. However we did not see any change in practice at the time of the unannounced inspection.
- At Blandford MIU, patients rang the bell and a nurse came to the waiting room to talk to them. If non-urgent, the patient was asked to sit and wait until the nurse was available. Nurses said they would give patients pain relief, without being assessed whilst they were waiting to be seen. This was of concern to the inspection team as the patient's medical history, allergies or medications taken would not have been assessed and this could put a patient at risk. Two patients were observed waiting in the waiting room for an hour and 20 minutes and an hour and 30 minutes without triaging or clinical assessment by a nurse.

Inadequate

Are services safe?

- We were shown emergency call bells for summoning assistance from staff in the hospital in case of emergency. At Wimborne MIU, we observed staff did not respond to the emergency bell when tested. This was highlighted to the hospital matron who was in attendance at the time. The bell rang in the neighbouring ward, but staff did not respond as they were unsure what the noise was. At unannounced inspection, we tested the emergency bells at Weymouth, Portland and Shaftesbury MIUs. All were functioning, with neighbouring staff responding and attending the units to provide assistance.
- If patients became seriously ill and had a cardiac arrest, a 999 ambulance was called to give assistance and transfer them to the Emergency Department at the nearest acute trust.
- Intermediate life support and paediatric life support training was mandatory for nurses working in MIUs. Training records showed Wimborne and Shaftesbury were 100% compliant and Weymouth and Portland 80% compliant. However, 33% of staff at Blandford had not completed the training and 67% at Sherborne, Swanage and Bridport. This meant staff were not updated in responding to patient emergencies.
- We found mental health patients were seen and assessed by the nurse and a proforma was completed to assess the risk and referral made as appropriate to the crisis team.

Staffing levels and caseload

- Staff vacancies for whole time equivalent for nurses across all MIUs was 5 % and just under 1% for healthcare assistants. Vacancy rates were the highest at Weymouth and Portland MIUs with 29.6% and second highest at Bridport with 23.3%.
- Staff sickness rates for all MIUs were 4.7% for a 13 month period until the 31 May2015. The highest rates were at Blandford MIU at 34.8% and Shaftesbury at 14.9%.
- Staffing turnover for all MIUs was 16.8%, with the highest rate being at Weymouth and Portland at 35.3%.
- Some MIUs, such as Swanage, Wimborne and Blandford, used bank staff and no agency nurses to cover shifts. Other units such as Portland and Weymouth MIUs relied heavily on agency nurses as well as bank staff. An induction document was seen at Portland MIU for agency staff, but other units that did not use agency staff did not have any induction packages prepared.
- The staffing and skill mix across the MIUs was inconsistent. Nurses were either band 5, 6 or 7 with a variety of skills and qualifications, including occasional nurse prescribers. Not all nurses had completed the full emergency nurse practitioner course. All nurses we spoke with had undertaken a minor injury module. Many of the MIUs had no specialist children's nurse on the team. However, the band 7 lead nurses for Shaftesbury and Sherborne MIU held children's nursing qualifications as well as general nursing.
- Some of the MIUs had healthcare assistants on the rota and some had receptionist cover that matched their opening times, but others did not. Reception staff were not specifically designated to MIU. Some also covered outpatients, other clinics, the main hospital reception and the switchboard. Therefore their hours of work did not always correspond with the MIUs opening times. This posed a risk as the waiting room was not always manned by receptionists and patients were not flagged promptly.
- Some units were staffed by lone workers, including agency staff, which posed a risk to patients if waiting to be seen or if the nurse was unfamiliar with the unit. At the time of the inspection, a band five staff nurse had been left lone working at Shaftesbury MIU due to staff sickness. We also saw lone working at Sherborne, Blandford and Portland. This could pose a safety concern if the unit became busy or the nurse was tending to a sick patient. The nurse at Shaftesbury MIU said they often worked alone, although there should be two nurses on duty; and this meant patients did not get triaged. If the receptionist was concerned, they would bring a patient round to chairs outside the treatment room and alert the nurse on duty. Patients could wait two hours without being assessed, especially at weekends when the nurse was working alone.
- At inspection we found an agency nurse was rostered to be lone working at Portland MIU the following day, without having completed the in-house induction, shadowing or access to the intranet. This posed a risk as the lone nurse would not have been able to access treatment protocols and document on patients records if they had no access to the intranet. We raised this at the time of the inspection, but did not receive reassurance that adequate supervision would be provided. This concern was raised with the trust who told us this would not occur, and the lone agency nurse at Portland MIU was going to be given support and

assistance by an experienced nurse the following day. Permanent staff at Portland MIU told us they used a pool of regular agency staff who were familiar with the unit.

- At the unannounced inspection the locality manager gave us an action plan to address the short staffing levels and lone working arrangements at Portland MIU. A new protocol stated that an agency nurse must work a minimum of three shifts, one of which is shadowing, before they could work alone at Portland MIU. The locality manager said they would ensure that the band 7 clinical lead gave agency staff an induction and that all agency nurses must have access to the electronic patient record and a smart card if they were to work there. They told us Portland MIU would close if an agency nurse was not familiar with systems and unsafe to work alone.
- At the unannounced inspection, we found an agency nurse lone working at Portland MIU who had worked there once before a couple of weeks previously and at Weymouth MIU the previous day, but had not worked the three shifts specified above. They said that no-one had been to check on them to see if they needed any clinical support and guidance from the Weymouth MIU or within the hospital senior nursing staff on neighbouring wards or departments. They had not completed the induction package with a member of staff, but worked through it on their own to ensure they were familiar with the surroundings and processes.
- At times, some MIUs had to be closed due to the inability to staff them with either permanent, bank or agency staff. This occurred at Portland and Blandford.
- The MIUs were all nurse led, and some could call on support from clinical staff, nursing, medical and allied healthcare professionals in other departments around the community hospital when and if needed.

Managing anticipated risks

- Some of the MIUs varied their staffing establishment with seasonal demands. Those such as Swanage and Weymouth had more nurses and healthcare assistants on duty in the summer months to cater for holiday makers.

Major incident awareness and training

- The nurse on duty at Bridport MIU was aware of the management of anticipated risks and major incidents. They referred to a trust contingency plan that was to be followed in the event of a major incident. We were made aware that MAJAX, the NHS emergency planning, resilience and recovery guidelines were used, and due for review in November 2014, as mentioned by a nurse at Weymouth MIU. Swanage MIU had a contingency plan for the Ebola virus.
- At the time of the 2012 Olympics, Portland and Weymouth covered the sailing competitions. Two nurses were trained in major incident medical management and support. Nurses then cascaded the training to the rest of the team.
- A generic contingency plan was also available at some of the MIUs for chemical, biological, radiological, nuclear and explosive substances and in-house training was received.
- In emergency situations, the MIUs had a contingency plan to accept and treat more acute patients than usual, to support the acute trust emergency departments. This would also occur for a major road traffic accident, where plans were in place so patients could be treated at the MIUs if necessary.

Requires improvement

Are services effective?

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

Summary

We found some out of date NICE guidance but some treatment protocols were available for use in the MIUs. We were told of up to date guidelines held electronically, but these were not always accessible or used by staff, particularly agency staff. There was little auditing of adherence to guidance or monitoring of patient outcomes.

There was variation in the experience and skills of staff employed in the units and the required qualifications and competency checks were unclear, particularly for lone workers. There were inconsistencies in clinical supervision and continuous professional development with some staff receiving more support and funding than others, depending on their location.

There were good links with acute services and appropriate referrals. There were examples of close working with GPs, but some inconsistencies.

Verbal consent was obtained for care and treatment and this was sometimes recorded in patient records. Staff demonstrated understanding of the Mental Capacity Act (2005).

Detailed findings

Evidence based care and treatment

- Patients were at risk of receiving care and treatment that was not in line with current guidance as some copies of clinical pathways and protocols we saw in the MIUs were not in date. NICE guidelines seen in MIUs were not always the most current versions. For example at Bridport MIU the NICE guidance documents for head injury and for burns were out of date. Some clinical guidance kept in the unit was dated 2008 and 2009. We also observed out of date X-ray protocols and policies.
- Clinical pathways for different conditions were available for the staff to use, and these were mostly kept on the intranet. Some pathways and guidance were out of date such as the "history taking and clinical documentation" document that expired in May 2013. This was seen at Bridport and Weymouth MIUs. However, there were other treatment protocols we saw in use which were in date until October 2015.
- Paediatric emergency care protocols on the resuscitation trolley at Blandford MIU were current and in date. There were also other 'in date' protocols and guidelines for the treatment of trauma and asthma. We saw a copy of a proforma to be followed for head injury which followed latest NICE guidelines.
- Staff we spoke with did not appear concerned that out of date clinical information was available in the department. They told us up to date versions were on the intranet but when asked were not clear how to access them, or told us they had not used them before as they were new.
- On unannounced inspection we found an agency nurse lone working at Portland MIU had access to the computer system. However,they were not clear where the clinical guidelines were located on the intranet and there were no paper copies of treatment guidelines.
- Not all observed care and treatment was in line with best practice guidance, but staff appeared confident and competent in the treatments they provided.

Pain relief

- Patients records evidenced patients pain was assessed and pain relieving medicines administered as required.
- We observed a pain assessment being carried out at Swanage MIU where a patient received eye drops prior to a procedure. This was appropriately discussed with the patient and documented in the notes. At Bridport MIU we also saw a patient being given pain relief appropriately by the nurse.
- Paediatric pain assessment charts were being used at some of the MIUs, the charts used were not the same across the units. At Bridport MIU lego characters with facial expressions were used to determine the child's level of pain. At Blandford MIU the assessment chart had a large dial on the face for children to describe their level of pain.
- No controlled drugs were used for pain relief at the MIUs but Entonox gas was used when needed. Nurses administered pain relief through PGDs unless they held an independent prescriber qualification.

Requires improvement

Are services effective?

Technology and telemedicine

- All trust policies and protocols were kept on the intranet but many staff did not know how to access them, or when they tried, the documents were not there.
- Treatment protocols and clinical guidelines were also kept on the intranet, but some staff did not know where or how to locate them. However, a nurse at Blandford was able to show us where and how to access the relevant documents needed.
- Many staff at the MIUs stated they felt the intranet was not user friendly and it was difficult for them to locate documents and the advice they needed.
- There were no telemedicine links to the acute hospitals or specialist services.
- Staff at Swanage MIU accessed a virtual fracture clinic, where they were able to discuss patients with a specialist.
- Staff told us computer screens were not of a sufficiently high definition for reviewing X-rays. Minutes of team leads meeting in Weymouth MIU recorded that new X-Ray boxes had been purchased to view slight fractures with high definition.

Patient outcomes

- There was no evidence of regular monitoring of outcomes for patients attending MIU other than patient satisfaction through the friends and family test. Feedback received was positive.
- The MIUs monitored unplanned admission rates, for February 2015 these were 3.9% against a target of 5%.
- In 2014 an X-ray audit was undertaken for all nurses at Shaftesbury MIU and found in 88.2% of cases there was correct interpretation and diagnosis.

Competent staff

- Trust records showed overall compliancy in appraisal rates across the eight MIUs as 88%. Wimborne MIU was 100% compliant in appraisals and 100% in clinical supervision as of 31 May 2015. Shaftesbury also 100% compliant with appraisals completed. All other units were between 80% and 93% compliant.
- Informal supervision was undertaken at some of the MIUs including Swanage, Bridport or Portland, where nurses supported each other with supervision sessions. At Blandford MIU staff undertook clinical supervision every 4 months, this was documented and evidenced. Some staff had supervision and appraisals with the clinical lead for MIU but some were provided by the neighbouring ward or departmental manager, or the modern matron for the community hospital. This meant that some nurses felt that their line manager did not understand their job role and the issues they raised as they were not MIU nurses. One member of staff at Swanage told us that supervisions were not recorded.
- A nurse at Weymouth said the trust had agreed that the minimum requirements for nurses working in MIU was the emergency nurse practitioner course with a minor injury module that required a five day attendance. There must also be a physical examination assessment and portfolio that is supported by signed competencies, however these were not seen across the MIUs at the time of the inspection. The trust confirmed that MIU nurses are not required to have a Nurse Practitioner qualification, they are required to complete the Minor Injury Course.
- Some nurses were lone workers and some had not completed the full emergency nurse practitioner course. This meant they may not have had the extensive clinical skills and knowledge to see, treat and discharge patients competently on their own. The nurses we spoke with had undertaken a module in minor injury or illness.
- Competent staff were observed at Bridport MIU, with appropriate examination skills. Referral pathways were used and intervention provided from the acute trust to optimise patient care.
- Healthcare assistants at Swanage and Weymouth were positive about working in MIU and felt they had received appropriate training to do their job competently. They had extended their skills by learning to do electrocardiograms, phlebotomy, plaster of Paris application and wound dressings. At Swanage, the HCA also had shadowing time in theatre and on ambulances plus attended a dementia workshop. Some were working towards their National Vocational Qualification level 3.
- The HCA at Weymouth said they had received triage training from the band 7 nurse whom had developed a programme, and felt confident to undertake this role.
- Staff felt encouraged to develop and one HCA was accepted for paramedic training. Some but not all staff told us they had access to courses and CPD. Some nurses had attended a minor illness training module At

Swanage, if no funding was available for training the league of friends provided financial support. At Portland staff told us access to accredited courses was limited due to staffing and financial restraints.

- Nurses in all MIUs were attending the X-ray ionising radiation medical exposure regulations course. This would enable nurses to read and report on X-rays. Some MIUs were staffed by bank staff whilst this training was being undertaken, for example Swanage and Wimborne. At Blandford, all staff had already completed this course.
- There was no rotation to the acute trust emergency departments to maintain acute clinical skills for the nurses, but staff felt this would be beneficial.
- Emergency care practitioners from the ambulance service were employed in the MIUs.

Multi-disciplinary working and coordinated care pathways

- Collaboration with GPs across Dorset was inconsistent. Swanage MIU reported a good working relationship with the local GPs.
- There was some multi-disciplinary working within the community hospital settings, where MIU nurses would take blood tests for ward patients.
- MIU nurses accessed medical advice and referred patients to acute hospitals as well as specialist services such as tissue viability nurses regarding wound healing. They had good access to radiologists and orthopaedic or emergency department clinicians for advice on fractures.
- Swanage MIU, for example, had a direct line of referral to other clinical specialities such as fracture clinics, district nurses, plastics department and ophthalmology. They confirmed they could also speak to a senior doctor for advice when necessary.
- At Shaftesbury MIU there had been a cardiac arrest at a weekend when the MIU nurse was lone working. She summoned help from the GP working in the neighbouring out-of-hours clinic to give assistance. The patient had walked into the hospital main entrance and presented to the receptionist with chest pain. They were immediately brought round to wait outside the MIU treatment room and collapsed with a cardiac arrest. The MIU staff responded appropriately and they were promptly transferred to the acute trust by air ambulance. Once at the hospital, they received treatment and the patient survived. This demonstrated competent and prompt assessment and response by the MIU nurse.

Referral, transfer, discharge and transition

- All MIU nurses had referral rights to specialists for advice and ongoing care.
- We saw a nurse at Wimborne making a phone call to a specialist at an acute hospital to seek advice and arrange an emergency appointment to review a child with an eye injury.
- A nurse at Swanage told us that nurses could refer patients directly for community and cardiac services rather than having to go through the acute hospital emergency department.
- At Swanage MIU we found the referral process to acute hospital clinics had recently been changed, which meant that some patients had not received appointments. For example, the process for referral to fracture clinic appointments had changed which resulted in two patients not being given follow up appointments at the acute trust.
- MIU staff used a standard letter template for discharge summaries which were sent to GPs electronically.
- Information was sent to the social services team, following child attendance at MIU.

Access to information

- Some staff in rural MIUs told us of poor Information Technology connectivity which resulted in issues accessing the intranet and discharging patients from the electronic record system.
- MIU policies and procedures were held on the MIU desk top, which only MIU staff could access . There was a risk that staff supporting the MIUs, such as the matron of the hospital and the locality manager did not have immediate access to this information.
- Some GPs gave access to MIU staff to view their patient records electronically, others did not. At Bridport, nurses were not able to access GP's electronic records. At times this made it harder for the nurses to deliver care as they did not have the full information about the patient's medical history and treatments.
- Staff at Swanage and Blandford were able to access GP records on the patient electronic records. This was helpful in giving treatment or administering medication, as the nurse understood the patient's circumstances.

Requires improvement

Are services effective?

- MIU nurses had access to health visiting and school nurses records.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Informed verbal consent was obtained from patients before treatment was provided. We observed this process taking place in the MIUs at Swanage and Bridport. Treatment options were explained to patients who were then able to make their own treatment choices. There was no formal documentation completed to evidence patient consent had been obtained, but we saw verbal consent recorded in some patient records.
- MIU nurses also sought consent from patients to ensure they consented to representatives from the inspection team being present in the treatment rooms.
- In conversation, staff demonstrated a good understanding of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards and how it affected their work practices. Training about the Mental Capacity Act was included in the safeguarding training all staff completed.

Good

Are services caring?

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

Summary

Nurses were caring and compassionate across all MIUs we visited.

Patients spoke highly about the staff and were involved in decisions about their care and treatment.

We observed good staff and patient interactions where privacy and dignity were maintained.

Detailed findings

Compassionate care

- We observed caring and compassionate staff at all MIUs, especially at Swanage, Bridport, Blandford, and Portland.
- Staff demonstrated communication skills with patients and many adapted their care to meet patient needs. We observed a nurse at Wimborne MIU did not relate to a child in a friendly and open manner when the child was distressed and crying. The nurse spoke mainly to the mother, rather than the child, of late primary school age. Although the nurse was competent in treating the child, we did not observe reassurance and sympathy.
- At Swanage MIU, a nurse was empathetic to a patient suffering pain and anxiety. They fully explained the actions to take and allowed the patient to make the decision.
- We observed staff knocking before entering treatment rooms, when consultations were in progress with colleagues.
- In Bridport and Swanage MIU, teddies were given to children for being brave and receiving treatment in the unit.
- Friends and family test scores were completed for all MIUs on a monthly basis. Most units had good response rates. February 2015 data showed positive overall ratings of 82-97, and most received ratings of over 90.

Understanding and involvement of patients and those close to them

- We observed consultations and saw that patients were fully involved in their assessment and treatment process.
- Care and treatment was planned around the individual and their needs, and wishes were taken into account.
- A nurse at Bridport was seen giving a comprehensive explanation to a patient as to why they did not require antibiotics for their condition. Good interaction and explanation was also seen at Sherborne MIU, with details of discharge information.

Emotional support

- At Swanage MIU we saw 'thank you' letters from grateful patients.
- Staff were seen comforting patients and relatives in a supportive manner. For example, there was a daughter distressed about her mother living with dementia who had fallen.
- Nurses were seen at some of the MIUs adapting their treatment to suit the patient and their lifestyle. This was seen at Swanage with a young man who was given a hand splint. The patient did not particularly need the splint for his injury, but the nurse provided emotional support by giving it to him, so he had the confidence to carry out his normal tasks.

Requires improvement

Are services responsive to people's needs?

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

Summary

Many environment were cramped and reception areas compromised privacy and confidentiality. The poor signage to some units led to patients attending acute hospital when unnecessary.

There was not a formal process to ensure timely assessment of individual patient's needs, and this limited the responsiveness of the service. There was limited understanding of, or adjustments for, the needs of people with a learning disability and staff had not attended dementia training.

MIUs closed at times due to staff shortages and there was limited availability of X-ray services at some sites.

MIU staff supported the local community by providing an extension of practice nurse skills and services to avoid delays for patients receiving treatment close to home, thereby avoiding attendance at acute hospitals.

The trust had contributed to the Dorset wide review of clinical services, including urgent care services.

There was a clear process for patients to raise complaints and some, but not always, evidence of learning and improvement in the service as a result of complaints.

Detailed findings

Planning and delivering services which meet people's needs

- There was an MIU service specification policy, this expired in 2013 and we were told was in the process of being reviewed.
- Many of the MIUs including Sherborne and Shaftesbury assisted the community by providing practice nurse skills out of hours or at weekends to support local general practitioners. Contraception cover was provided as well as dressing changes and fitting of 24 hour cardiac monitoring tapes. Some nurses had concerns as this was out of the agreement for MIU services.
- The MIU service was based on historic attendances, and a full strategic review for the model of urgent care was underway. The CCG was reviewing the clinical services in Dorset, including urgent care, with final decisions on plans by March 2016 for implementation in July 2016.
- A nurse told us that several years ago commissioners surveyed the local populations with regard to their wishes for emergency health provision in Purbeck. The commissioners reviewed the model for MIUs and allowed autonomy to the nurses to judge if they were competent and confident in treating minor illnesses. If this was not in their scope of competency, then patients would be referred elsewhere for care and treatment.
- The service was part of the Systems Resilience Group, a multi-agency network made up of trust board members, the local authority, NHS England, GPs and the clinical commissioning group .
- Some MIUs were poorly signposted not only in the main hospital but also in town, so the units were difficult to find for visitors. Swanage had a hand made sign on the door of the main hospital building giving details of the MIU. The signs at the hospital and in town said 'hospital, no accident and emergency department' but did not mention there was an MIU on site. This meant local people in the community as well as visitors did not know that an MIU was present, or what conditions they could attend with. During the inspection we observed a patient arriving at Swanage with a minor injury who was about to leave as the signage indicated no A&E. They would have driven to an acute hospital if not advised of the MIU service by the inspection team.
- The MIUs were located in community hospitals and some were in cramped environments. Some treatment rooms such as at Wimborne MIU were cramped and provided limited access for staff and patients. They were too small to accommodate a patient or visitor in a wheelchair. The nurses office was also very small. These concerns were listed on the trust wide risk register with an action target date for June 2015.
- Most reception areas that serviced the MIUs did not allow confidential conversations to take place. We saw many MIUs including Shaftesbury, Weymouth and Portland where patients were required to discuss their reason for attending in an open area with other patients waiting. Patients booking in were overheard by everyone in the waiting room and this breached confidentiality and their privacy. At Weymouth MIU there were Perspex see-through panels between the three reception desks that were located next to each other,

but this provided no privacy or reduced sound. This issue was placed on the trust wide risk register in April 2015, and due for review in April 2016. An action plan was given to us at the unannounced inspection by the locality manager of how they aimed to address this.
- MIU treatment rooms had doors or curtains to maintain privacy and dignity when patients were being treated.
- Some MIUs such as Sherborne and Portland had information screens in the waiting room opening displaying opening times.
- Most MIUs such as Swanage, had an allocated children's area in the waiting room that contained children's toys and child friendly wall paintings.
- There was evidence of planning to adjust to seasonal demand. Staffing levels were increased in the summer months in Swanage due to holiday makers. This included additional health care assistants, nurses and administrative staff to cover weekends..
- Locality meeting minutes evidenced a request from commissioners for extra cover provided by MIUs over the Easter period.
- At Sherborne two staff were rostered for a Monday, when there were more attendances at the MIU.
- Swanage MIU had developed ambulatory care to avoid hospital admissions and provide care closer to home for the local population. This included treatments such as intravenous antibiotics and injections.
- At unannounced inspection, we found measures had been put into place to mitigate risks at Portland MIU, following our findings. The opening times had been revised, and we saw a document that described the changes to be made from 13 July 2015. Portland MIU would not be open evenings or weekends so that the opening hours were in line with reception cover and other departments in the hospital that provided day services. Weymouth MIU would cover the shortfall as their opening hours were 8 am to 10 pm seven days a week.

Equality and diversity

- There were no adjustments to accommodate visually impaired or hard of hearing patients.
- There was no patient information in foreign languages.
- Swanage had disabled access to the entrance and disabled toilet facilities, but others did not. Bridport MIU access was up a long slope at the side of the building, and there were no automatic doors. Wheelchairs were available but not always easily accessed.
- Some units such as Wimborne had the car park located some distance from the MIU main entrance which would prove difficult for patients attending that had injured limbs, or if elderly or frail.
- Some X-ray facilities, such as at Sherborne and Wimborne MIU, were located some distance from the department which could prove difficult for patients with restricted mobility.

Meeting the needs of people in vulnerable circumstances

- Staff told us that vulnerable patients normally attended MIU with a relative, spouse or carer.
- There was little staff awareness or adjustments for people with a learning disability.
- There was literature in the MIU waiting rooms on health promotion, sun safety, cyber bullying and PALS leaflets, but no large print or easy read leaflets.
- There was variable understanding of how to involve patients living with dementia and not all staff had attended dementia training. A healthcare assistant at Swanage told us it was common to see patients who were living with dementia. They explained how they involved both the patient and their carer/relative during the assessment, planning and the delivery of treatment.
- Some of the MIUs we visited displayed the names of the nurses on duty, and the waiting time to be seen, however this did not occur at some MIUs such as Shaftesbury and Weymouth. The receptionist would verbally tell the patients how long the wait would be after speaking with the MIU nurses.
- MIU staff could access the community mental health and crisis team to support patients with mental health needs if necessary.

Access to the right care at the right time

- All MIUs met the national target for patients to be seen, treated and discharged within four hours. Over the last year 2014-2015 this was achieved for between 99.9-100% patients across the MIUs. At Bridport, a nurse told us there had been times when patients were still in the hospital after the four hour target, but this was due to waiting to see if the patient would suffer side effects from treatment received or accessing services elsewhere in the hospital.
- The waiting times at the MIUs were generally short, with exceptions seen at Weymouth MIU at the time of the inspection. February 2015 data showed time from arrival

to treatment was an hour for 79% patients across the MIUs. All but a few patients were seen before leaving, 0.3% patients left without being seen against a target 5%.

- However we found patients arriving in the MIUs were left waiting for varying lengths of time without clinical assessment by a nurse. This meant their needs were not assessed and prioritised. Also patients could be waiting to be seen by the MIU nurse, only to find the nurse could not treat their clinical condition and they needed to attend the local acute hospital emergency department.
- We observed one family arrive at an MIU as a family member had increased pain following a road traffic accident the previous day. They were booked in by a receptionist but waited one hour 47 minutes to be seen by a clinician.
- When an MIU service was provided by a lone worker, for example at Shaftesbury, anyone arriving after 5.30pm, or 30 minutes before the advertised closing time, was sent to the local acute emergency department.
- Sometimes MIUs were closed due to staff shortages, this was a particular issue at Portland MIU.
- The access to X-ray facilities was limited, not operating every day or for the duration of MIU opening time, and protocols restricted the types of X-ray available. X-ray services were not available at weekends. When X-ray was closed MIU staff referred patients to the nearest community hospital X-ray department or the acute hospital. For example, Portland had limited X-ray facilities, so patients would be redirected to Weymouth. If not urgent the patient was sent home with a splint and asked to return the following day.
- Where X-ray services were available and the nurses were trained to interpret, a diagnosis could be given promptly and treatment commence without delay. At some MIUs, X-rays were reported on within a 72 hour period so nurses could cross check with the original diagnosis.
- MIU nurses made direct referrals to some acute services to avoid delays. For example, patients were referred directly for cardiac angiography treatment rather than them having to go through the emergency department at the local acute hospital.

Learning from complaints and concerns

- Evidence of learning from complaints did not always address underlying system issue.
- Staff told us if a patient or relative was unhappy or wanted to make a complaint, they dealt with it at the time and tried to resolve the issue themselves. If this was not possible, they would either ring the patient at home at a later time, or pass it to a more senior nurse to answer.
- There were some patient advice liaison services leaflets at some of the units, with information displayed on how to make a comment or complaint.
- From 1st April 2014 to 31 March 2015 there were 15 formal complaints across MIUs: Shaftesbury four, Weymouth three, Portland two, Bridport two, Blandford two, Swanage one, Sherborne one. Most staff we spoke with were not aware of any complaints about MIU services.
- We heard from one staff member that they no longer answered the phone when lone working. This followed a complaint about their telephone manner when they had been under pressure of work and working alone in a MIU. Clinical staff were expected to respond to queries and answer phone calls while caring for patients. This resulted in avoidance to answer the phone, which we felt was not a solution and could pose a risk to patients.
- We were told of actions following a complaint of missed diagnosis from a patient brought to MIU by ambulance. A list of what could be seen at MIU was sent to the ambulance service to stop inappropriate referrals.
- Minutes of a Dorset Locality meeting discussed a complaint regarding a long wait to be seen by a member of staff and whether a triage nurse should be on reception in the MIU.

Requires improvement

Are services well-led?

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

Summary

The MIU staff were unclear about the vision and strategy for the service. They were aware of a clinical services review being undertaken across Dorset by Commissioners, but did not feel informed or consulted. The service specification was outdated and not being followed as it did not reflect the current service provided by the MIUs.

The trust governance frameworks did not always operate effectively for MIU services. There were insufficient processes for proactively identifying, assessing and managing risks and seeking staff views. There was insufficient auditing of quality or learning across the different services.

We found variations in the quality of clinical leadership across the units, some units such as Blandford and Swanage MIUs were led well, which resulted in an organised service. However, at Weymouth, Portland and Bridport MIUs we found some serious issues. . Leadership to MIU staff was provided by the community hospitals management team and staff had a variety of managers. Some had no specific knowledge or experience in emergency nursing, and accountabilities were sometimes unclear. Although staff enjoyed their jobs in MIU, they felt isolated and did not feel valued by the trust. There were improvements in the services in some areas but not all staff were encouraged or felt that they could raise ideas for innovation.

Detailed findings

Service vision and strategy

- The service leads for urgent care services had vision and a strategy for the future of the MIUs as part of integrated care, and they had contributed to the ongoing Dorset clinical services review.
- A model was being trialled at Weymouth where MIU, the walk in centre and out of hours were integrated and worked side by side in collaboration with the ambulance service and primary care. The trust had been involved in the design and will be bidding to provide the service in collaboration with local GPs and the acute hospital and will evaluate the service. The service leads told us if successful this would become a model for the other MIUs.
- Staff in the MIUs felt they were unsure of the strategy and vision for the future. The outdated service specification was not being followed as it did not reflect the current service of the MIUs.
- Staff were aware that the service provision was under review. A nurse at Portland MIU spoke about the vision for developing GP led services, but was not clear about the future service provision of MIUs. MIU nurses in general told us they did not know what the future held for the MIUs in Dorset.
- At Bridport MIU, a display outside the waiting room showed the trust's quality priorities for 2015/2016. The information board also displayed the values for MIU which were compassion, communication, commitment, courage and competence.

Governance, risk management and quality measurement

- The governance structure was linked to localities and community hospital matrons attended locality governance meetings, where issues relating to hospital services including MIUs were discussed. MIUs were not always clearly linked into the governance structure.We found that local hospital governance meetings were held but we found variation in representation of MIUs. For example, heads of department meetings were held at Swanage Community Hospital, but there was no representation from the MIU.
- There were local team meetings for some but not all MIUs. Minutes of staff meetings at Wimborne MIU and Blandford hospital evidenced discussion of relevant clinical issues. Examples were review of the risk register, the importance of reporting incidents, medication errors and near misses. Weymouth team leads meeting minutes recorded discussions of MIU and staffing shortages. We were told Shaftesbury MIU team meetings had not been held due to sickness absence.

Requires improvement

Are services well-led?

- Quarterly meetings had been started across the MIUs to promote joined up working and coordinated care pathways. However only two staff attended the last one so they planned to reschedule it. The last MIU team leads meeting occurred in January 2015.
- Staff could not tell us what was on the trust risk register as they could not access it, but they knew that staffing would be highlighted. At Swanage and Bridport, the senior nurses could not locate it in its regular place on the intranet. An updated MIU and trust wide risk register was provided at the unannounced inspection by a locality manager.
- The risk registers included concerns raised by staff but also issues raised at our announced inspection. Lone working in the MIUs was on the trust wide risk register from April 2015 with action dates set for July 2015 to address concerns. Other items included the lack of triage at Weymouth MIU, and the safeguarding flag on patient records that had not been noticed by reception staff and nurse alerted. Both of these concerns had been raised by the inspection team, and had been placed on the risk register during the inspection week. There was also an entry regarding the risk of service disruption during transition to a new urgent care service model.
- Blandford MIU had listed an issue with lone working and not answering phone calls when in patient consultation on the risk register in May 2015. It stated that the Day Surgery Unit staff would answer the phone on their behalf in order not to be interrupted delivering clinical care.
- Unsafe nursing and administrative staffing levels was placed on the trust wide risk register with a target date of September 2015, with a plan to re-advertise unfilled posts. The lack of pharmacy support to the MIUs was on the trust wide risk register, with plans to recruit more pharmacy technicians and pharmacists. The effectiveness of plans were not clear.
- There was limited evidence of audit and quality monitoring across the MIU services. At Wimborne MIU we saw a service review document dated 2013 that contained an action plan and made recommendations but it had not been updated or reviewed.
- There were localised audits, for example a sharps audit that took place in December 2014 in one MIU, a resuscitation trolley audit was completed at Blandford MIU in April 2015, and a record keeping audit for all the MIUs was completed in March 2014.
- An action plan was handed to us at the unannounced inspection. This evidenced the trust had listened to the feedback given from the inspection team, and were working to address the issues raised and implement change. However, there were not sufficiently robust processes in place to identify, assess and manage those concerns and risks prior to the inspection.

Leadership of this service

- We found good local organisational and clinical leadership at Blandford, where the matron had an MIU background, and Swanage MIU was well organised. But there was variation and insufficient clinical leadership in many of the units.
- The MIUs were sited within community hospitals and clinical leadership was provided by the local hospital management team. The nurses reported to a variety of band 7s from disciplines including physiotherapy or occupational therapy. Some of them were ward sisters on neighbouring wards or day surgery units within the hospital, and the MIU was seen as a department within the community hospital rather than a stand-alone urgent care service. Clinical leads were often not emergency nurse practitioners, nor did they have experience of working or managing MIUs. There was often no band 7s leading the MIUs, with a few exceptions such as Weymouth and Bridport. Some band 6s took on the role of leading the units, but this was informal. Some staff told us they were not sure who they were accountable to, and who was actually in charge of the MIU. A nurse at Bridport had recently gained a band 7 role, and was given the clinical lead for the MIU. The nurse had improved child and adult protection procedures when arriving on the unit, which were then implemented throughout all MIUs.
- The modern matron at Wimborne community hospital told us trust board members such as the director of nursing had visited, but this was not mentioned by any other staff or at any other units.
- There was a lack of overarching leadership for the minor injuries unit services across the trust.
- Staff said there used to be nurse a consultant who had overarching leadership of the MIU service. However, this post was no longer in existence, which they felt had a negative impact on the communications between units and teams. The matron at Blandford had been allocated as professional lead for the MIUs but we found the units worked in silos.

Requires improvement

Are services well-led?

- A retired senior nurse had recently been appointed to cover the MIUs for two days a week on a fixed term contract. They had plans to integrate the units by providing leadership and aiding communication, but this had not yet had an impact.

Culture within this service

- MIU nurses generally felt that the trust did not recognise the responsibility of their role or appreciate their work. They felt there was support from the modern matrons, the hospitals they worked in and the local community, but not at trust level. Some staff did say this was improving.
- Staff at Swanage said they would recommend the MIU as a good place to work, and would feel comfortable is raising concerns or whistleblowing to the trust.
- We saw good working relationships between staff in different departments in the community hospitals. MIU staff undertook blood tests for ward staff, and assistance was given to them in an emergency situation if necessary.
- Staff in all MIUs said they were happy in their jobs and felt proud to be an MIU nurse. This was supported by HCAs who were also very happy in their role. The main criticism from staff was the inconsistency in leadership roles expected from different grades across the units. They were concerned by the problems recruiting emergency nurse practitioners and the grading offered.
- We found that staff did not wear a standardised uniform across the MIUs and some nurses were seen wearing inappropriate shoes. Some wore theatre scrubs, some tunics and their own trousers and some wore uniforms. It was difficult to distinguish the different grades and levels of staff, as this was not evident by the uniform or a name badge. It was not clear who was the nurse in charge of the shift.

Public engagement

- We saw avery active League of Friends across community hospitals, this was particularly evident at Swanage Hospital and MIU. They liaised with the community and communicated their views to their local hospital.
- The ongoing clinical services review across Dorset included urgent care services and was due for public consultation in August 2015.
- Portland and Blandford MIU reported that the uptake on the FFT had decreased since they changed the method in which people gave feedback. There used to be a touch screen token system but this was removed by the trust. Patients and visitors felt it was beneficial and less complicated to use than the newer method.

Staff engagement

- Staff told us they were not consulted for the clinical services review of the MIUs.
- There was variation in how well staff felt able to raise their views. Several were concerned about the staffing, that they felt overwhelmed and had little support. They told us they would like more support for assessing and booking patients. They were not clear these concerns had been heard.
- Regular meetings were held with staff at some services such as Blandford and Wimborne but this was consistent across the MIUs. Staff meetings had been attempted at Shaftesbury MIU but had not been regular due to sickness absence.
- Staff at Swanage spoke of their desire to develop their own fracture clinic so patients would not need to travel, but it was not clear if this proposal had been formally raised with the senior management.

Innovation, improvement and sustainability

- Bridport and Wimborne MIUs had applied to relocate the MIUs to an alternative location within the hospital setting, increasing size and possibly opening hours. This would also locate them closer to X-ray and social services and the car park.
- Service leads told us they looked at financial viability of MIUs but looked for opportunities for expansion of services before consideration of closure. They were exploring options to expand the services to support seven day working for GP's.
- The MIU model being designed at Weymouth MIU showed innovation and sustainability as the trust were striving to meet the needs of the population within the constraints of budgets and Commissioner requests.
- The trust was starting to engage with the acute hospital in West Dorset in work to develop urgent care and MIUs pathways.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met: People who use services and others were not protected against the risks associated with unsafe care or treatment because** • National guidance on triage and clinical assessment in urgent care services was not followed to ensure provision of safe care. Regulation 12(1) • Patients attending MIU did not receive timely clinical assessment to identify their needs and any immediate risks to their health and wellbeing. Regulation 12 (2) (a) • Persons providing care or treatment did not always have the competence and skills and experience to do so safely. Regulation 12 (2)(c) • Equipment used for care or treatment was not always checked to ensure it is safe for use. Regulation 12 (e) • Medicines were not always managed properly and safely. Regulation 12 (2) (g)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was not being met:** • Systems and processes were not operating effectively as not all staff were up to date with training or confidently identifying and responding to child protection flags. Regulation13 (2)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: • There were not always sufficient numbers of adequately experienced and skilled staff to meet the requirements set out in the fundamental standards. Regulation 18 (1) • Not all staff received the appropriate training, support and clinical supervision to enable them to carry out the duties they are employed to perform. Regulation 18 (2)
	How the regulation was not being met: Systems were not in place to • Assess, monitor and improve the quality and safety of the services provided. Regulation 17 (2)(a) • Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Regulation 17 (2)(b) Seek and act on feedback from relevant persons for the purposes of continually evaluating and improving the service. Regulation (2)(e)