

# Derby Hospitals NHS Foundation Trust

# Royal Derby Hospital

## Quality Report

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

## Ratings

### Overall rating for this hospital

**Good**



Urgent and emergency services

**Good**



Medical care

**Good**



Surgery

**Good**



Critical care

**Good**



Maternity and gynaecology

**Good**



Services for children and young people

**Good**



End of life care

**Requires improvement**



Outpatients and diagnostic imaging

**Good**



# Summary of findings

## Letter from the Chief Inspector of Hospitals

Derby Hospitals NHS Foundation Trust provides both acute hospital and community-based health services. There are two inpatient hospitals, the Royal Derby Hospital and London Road Community Hospital. The trust serves a population of over 600,000 people living in Derby and the surrounding areas. In total the trust has 1,100 beds.

Derby is an urban area with a deprivation score of 63 out of 326 local authorities (with one being the most deprived). This means that Derby Unitary Authority has a significantly deprived population and is worse than the national average on a range of population health measures.

Life expectancy for men is lower than the England average and is 12.2 years lower between the most deprived and the least deprived areas of Derby. For women the difference is nine years lower. Reducing inequalities in health is one of the local priorities across the Derby health community.

We inspected Derby Hospitals NHS Foundation Trust as part of our comprehensive inspection programme.

We carried out an announced inspection of the Royal Derby Hospital, London Road Community Hospital as well as the community-based services between 8 and 11 December 2014. In addition, an unannounced inspection was carried out between 5pm and midnight on 22 December 2014. The purpose of the unannounced inspection was to look at the accident and emergency (A&E) department, critical care and a number of wards in both the Royal Derby Hospital and London Road Community Hospital.

We made judgements about all of the services the trust provided and because just three out of the eleven core services we inspected required improvement we rated this trust as “good” overall and noted some outstanding practice and innovation. However, improvements were needed to ensure that services were safe, effective and well led.

Our key findings were as follows:

### Cleanliness and infection prevention and control

- There was a dedicated infection prevention and control team and good arrangements in place to prevent the spread of infection. All of the wards at the Royal Derby and the London Road Hospitals appeared to be clean. We saw staff adhered to the policies for infection prevention and control, for example, staff washed their hands regularly and between patient contact. Where infections did occur, they were subject to an investigation. We saw examples of these investigations and the learning points to come out of them.

### Nutrition and hydration

- We saw patients received help to eat and drink. There were systems in place to identify patients who needed help, such as the "Red Tray," and protected mealtimes. There were nutritional assistants available at meal times. We also noted some good practice for patients where the day rooms were used to have communal meals and create a more informal atmosphere to help stimulate patients to want to eat and enjoy their meals.
- Nutritional risk assessments were completed appropriately, but most importantly we saw the outcomes of risk assessments were acted upon. Food charts were maintained and there was accurate recording and totalling of fluid balance charts.

### Mortality

- We did not have concerns about mortality rates at the trust. Where there had been any identification of trends that required further investigation the trust reviewed data and submitted their responses appropriately. There had been a

# Summary of findings

mortality outlier which intelligence systems had identified in February and March 2014. This concerned coronary atherosclerosis and other heart disease. An investigation had been undertaken which identified a need to ensure improvements in coding and documentation. The clinical treatment of the patients was not found to be of any concern.

- The trusts Summary Hospital-level Mortality Indicator (SHMI) and the Hospital Standardised Mortality Ratios (HSMR) mortality measures show the trust as being within expected limits between August 2013 and July 2014. SHMI and HSMR are ways in which the NHS measures healthcare quality by looking at the rates of mortality in the trust.

## Staffing

- A recognised safe staffing tool had been used to calculate nurse staffing levels. During 2014, a review had taken place and changes to the establishment had taken place. Wards displayed their staffing levels on a board and it compared the daily planned numbers of staff with the actual staff on duty. Patients at the Royal Derby Hospital told us the nurses were busy. Many staff told us they felt under pressure and worried that their workloads kept on increasing as the demand for services increased. Despite this, we found all of the services we inspected apart from medicine were adequately staffed with nurses. In medicine and end of life care, there were some occasions where the nursing staff ratios dropped to below the required level.
- The trust employed more consultants and junior doctors than the national average but less registrars and middle grade doctors than the national average. Doctors we spoke with were generally positive about the medical staffing arrangements and we did not identify any concerns with the numbers of medical staff employed by the trust.

We saw several areas of outstanding practice including:

- The trust was providing responsive care for patients who had dementia. On the Medical Assessment Unit there was a dedicated lounge known as the FEAT lounge (frail elderly assessment team). A dedicated healthcare assistant with qualifications in caring for patients living with dementia to assist patients was available in this lounge every day. We found this was providing care to patients that was very responsive to their individual needs.
- Ward 205 should be commended for helping to improve the mental wellbeing of elderly patients and patients with dementia through the use of the reminiscence room, pictorial information and advanced service planning to further enhance care.
- The MAU had pharmacists on the ward 12 hours each day, seven days a week. They worked as part of the frail elderly team with the aim of optimising the use of medicines. The overall aim was to help patients make the most of their medicines.
- Respiratory medicine had introduced the use of patient colour-coded wristbands to identify how much oxygen each patient needed. Excessive amounts of oxygen can be dangerous for some patients and it is important that the correct amount of oxygen is administered.
- Echocardiography was used as the main monitoring tool of cardiac output and fluid status for intensive care patients. Point of contact echocardiography for these patients is a highly innovative and valuable service.
- The maternity department bereavement service had been recognised by the Royal College of Midwives. The lead midwife had been nominated for the Royal College of Midwives Award 2015 National Maternity Support Foundation Award (NMSF) for Bereavement Care, improving the environment, which was known to be an important key to effective bereavement care.
- The Nightingale Macmillan Unit was dedicated to providing end of life care to patients with life-limiting illnesses and staff were able to respond appropriately to meet the individual needs of patients. The facilities and resources available for patients on the unit were excellent

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

## Importantly, the trust must:

# Summary of findings

- Ensure all DNA CPR order forms are completed accurately in line with trust policy and the Mental Capacity Act (2005).
- Ensure there are sufficient numbers of suitably qualified and skilled staff within the medical and end of life care services.

## **In addition the trust should:**

- Ensure that the lone working policy and arrangements for community maternity staff are reviewed to ensure they feel safe and secure when out in the community.
- Ensure that patients notes are stored securely to ensure that confidential patient information is not accessed inappropriately.
- The trust should ensure that there are sufficient numbers of suitably qualified, skilled and experienced nursing staff on the adult emergency observation ward to safeguard the health, safety and welfare of patients.
- The trust should ensure that there is sufficient storage available to enable equipment to be appropriately stored and enable safe access to bathrooms on medical wards.
- The trust should consider providing information for patients and friends and family comment cards in different formats and different languages. This will enable people with learning disabilities, those who's first language is not English or those with cognitive impairment to access information and provide their feedback.
- The trust should review arrangements for undertaking venous thromboembolism (VTE) assessments on the surgical assessment unit.
- The trust should consider reviewing arrangements for the care of patients on high dependency units who would be categorised as level two as current arrangements are not meeting the Core Standards for Intensive Care Units 2013.
- The trust should consider developing their electronic prescribing system to enable it to be used in intensive care as for other wards and departments in the hospital. The use of different systems across the hospital meant there was a risk of poor communication about previously administered medications.
- The trust should ensure that staff on Puffin ward are trained and supported to care for patients who require a CAHMS assessment whilst on the ward so that they can ensure their welfare and the welfare of other patients is protected.
- The trust should ensure that all clinical single use equipment is stored safely and appropriately; and disposed of when it has expired it used by date.
- The trust should ensure that the design and layout of the neurology outpatient clinic at London Road Hospital is suitable for the needs of all patients, including those with limited mobility.
- The trust should consider improving the facilities for patients who need to collect prescription medicines from the pharmacy within Royal Derby Hospital. This is to reduce the long waiting times for prescriptions to be dispensed and the pharmacy and improve access for patients with limited mobility.
- The trust should consider hearing "patient stories" during their public board meetings to ensure the positive and negative experience of patients is taken account of when they make decisions.

## **Professor Sir Mike Richards**

Chief Inspector of Hospitals

# Summary of findings

## Our judgements about each of the main services

### Service

#### Urgent and emergency services

### Rating

Good



### Why have we given this rating?

The adult and children's emergency departments at Royal Derby Hospitals were safe. Reliable systems and processes were in place to promote safe care, and emergency preparedness plans were in place. Patients received care and treatment based on best available national evidence-based standards and guidelines. Effective and consistent levels of care were available 24 hours a day, seven days a week. Patients and relatives were all positive about the care they had received. Staff offered care that was kind, respectful and considerate. They responded to patients' anxiety or distress with compassion, and offered emotional support.

The department was not consistently meeting the four hour waiting time target for emergency departments. However, staff in the department were leading work within the wider trust to support improvement in this area. The department was dealing with unprecedented demand at the time of our visit, but there was always a calm atmosphere and a clear sense of purpose amongst the staff team. Leadership and management of the emergency department focussed on the delivery of high-quality, person centred care. There was a positive culture with a strong team ethos and consultants in the department were approachable, committed and passionate about continuous improvement.

### Medical care

Good



Medical and nursing staffing levels generally met the required standard. However there were some occasions where the actual number of registered nurses fell below the required number. A need to recruit further staff in these areas had been identified by the trust.

There were suitable arrangements to identify and manage risks, and to monitor the quality of the service provided. There had been a reduction of the number of patient harm incidents such as pressure ulcers and ward-based falls.

Staff told us they were encouraged to report safety incidents and they received feedback. Care was provided in line with national best practice.

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guidelines. The trust has had mixed performance in comparison with other hospitals which provided similar types of treatment. We observed all levels of staff demonstrating a caring attitude towards their patients, treating them with dignity and protecting their privacy.

## Surgery

Good



The surgical division had systems and processes in place to keep patients safe. Staff had a good awareness of the process for identifying and recording patient safety incidents. Arrangements to minimise risks to patients were in place, with measures to prevent falls and pressure ulcers, the early identification of patient risk during surgery, good infection prevention and control practice and, the safe management of medicines. Staff were competent and suitably trained to deliver care in line with trust policies and procedures, national guidance and, National Institute for Health and Care Excellence (NICE) quality standards. Access to care, treatment and surgical outcomes for patients were mostly within the national average. Where improvements were required these had been identified and measures were in place.

## Critical care

Good



There were safe levels of medical and nursing staff, and staff were supported to develop and maintain clinical expertise. Competent medical, nursing and other professionals worked effectively together to ensure safety. There was one never event in the week prior to our visit which was fully investigated, procedures were amended and information cascaded to staff to reduce future risk. All patients and relatives we spoke with told us that staff were supportive, efficient and caring. The service provided follow-up arrangements for patients who had been cared for in intensive care to reduce emotional and psychological distress after their experience. There was effective clinical leadership and managers worked closely to support improved patient care. Clear plans, protocols and procedures meant that the staff were aware of their responsibilities. Arrangements for the management of level 2 patients in the high dependency units did not meet national standards. There was daily review by medical consultants but there was no routine

# Summary of findings

involvement or support from intensive care consultants. Nursing staff were working to competency frameworks relevant to their specialty but few had critical care qualifications. Audits of performance, and outcomes for patients, in the high dependency areas were not compared against similar care units nationally.

## Maternity and gynaecology

Good



The named midwife model was in place and women told us they had a named midwife. This process then proceeded to one-to-one care being offered by midwives on labour ward. However, midwives told us that it was currently less likely to happen, due to the demand on the ward.

We identified one set of records with important 'birth event details' absent. This was highlighted to the team and the event was retrospectively written into the notes to support a safeguarding situation. We met with the safeguarding midwife to discuss an incident. We were told that the trust did not have a bruising policy; the non-accidental injury policy was followed. A non-accidental injury (NAI) is defined as any abuse purposefully inflicted on a person; this abuse can be physical or emotional.

The birth centre promoted a 'home from home' experience for patients who wished to have the comforts of a home birth with the added reassurance of being in a hospital. The fertility unit was open seven days a week. They aimed to achieve a pregnancy for as many couples as possible. Community staff reported being concerned that at times their safety was compromised when lone working. They felt uneasy about walking in to some situations. Currently they did not carry security alarms or have any system whereby their whereabouts were logged.

## Services for children and young people

Good



Staff on the children's wards and the neonatal unit worked hard to provide safe care. There were arrangements in place to monitor incidents, and staff were clear on their responsibilities. Staffing levels were appropriate at the time of our visit, although we were aware there were pressure points in some areas.

Children were treated according to national guidance. We observed many examples of compassion and kindness shown by staff across all the departments and ward areas.

# Summary of findings

Services were planned and delivered to take into account local need. The capacity of the neonatal unit was stretched at times but there were plans in place to introduce more cots in early 2015. Services for children and young people were well-led. There were clear governance arrangements in place.

## End of life care

### Requires improvement



We found inconsistencies in completion of do not attempt cardio-pulmonary resuscitation (DNACPR) forms across the hospital, including mental capacity assessments. Mental capacity assessments were not completed for 93% of patients deemed not to have capacity to make and communicate decisions about cardio-pulmonary resuscitation. End of life care followed national guidance and the trust participated in national audits. However, there were inconsistencies with the use of end of life care documentation across the trust. The trust planned to implement a rapid discharge 'home to die' pathway in 2015. The fast-track discharge pathway used was not effective. Patients and relatives all spoke positively about end of life care. Staff were enthusiastic and passionate about the quality of care they provided.

## Outpatients and diagnostic imaging

### Good



There were reliable systems, processes and practices in place to protect patients from avoidable harm and abuse. Risks to patients using the services were assessed and appropriately managed. Patient needs were assessed and their care and treatment were delivered in line with local and national guidance for best practice. Consent to care and treatment was obtained in line with legislation and guidance. Staff were suitably qualified and skilled to carry out their roles effectively and in line with best practice. There were good examples of staff working collaboratively to meet patient needs. Patients spoke positively of staff they came into contact with. Staff were observed to be caring and compassionate in the way they dealt with patients and their families or carers. They were knowledgeable and enthusiastic about the service they provided and this was reflected in how they engaged with people.



Good 

# Royal Derby Hospital

## Detailed findings

### Services we looked at

Urgent & emergency services, medical care (including older people's care), surgery, critical care, maternity and gynaecology, services for children and young people, end of life care, outpatients & diagnostic imaging

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# Detailed findings

## Background to Royal Derby Hospital

The Royal Derby Hospital is a new, modern, purpose-built hospital, which was officially opened in April 2010. The hospital also incorporates the Derby Graduate Entry Medical School and the School of Health Sciences.

Derby is an urban area with a deprivation score of 63, out of 326 local authorities (with 1 being the most deprived). This means that Derby Unitary Authority has a significantly deprived population and is worse than the national average on a range of population health measures.

The local health profile shows that Derby has a number of indicators that are worse than the England average. In 2011, 24.7% of Derby's population were from Black and minority ethnic groups, the largest group being Asian/Asian British. This is significantly higher than the England average of 14.6%. 13.9% of the population, in 2011, were born outside of the UK.

The trust was rated as band 2 in the December 2014 update of the CQC's intelligent monitoring system (the scores range from bands 1-6, with band 1 being the highest risk and 6 the lowest). The highest risks within our monitoring were:

- Composite indicator: In-hospital mortality – dermatological conditions.
- Composite of hip related Patient Reported Outcome Measures (PROM) indicators (1 April 2013 to 31 March 2014).
- Monitor – governance risk rating (9 September 2014 to 9 September 2014).
- Monitor – continuity of service rating (9 September 2014 to 9 September 2014).

In 2013/2014, the trust had a total income of over £477 million and a deficit of over £15 million. It employs 8,779 staff.

The trust was placed in breach of its Monitor license in September 2014 for two areas: breaches and finance.

The breaches related to failure to meet nationally set targets regarding access to services and the trust's financial deficit. The trust have provided plans to Monitor of how they are addressing the breaches.

The inspection did not include the Radbourne Unit on the Royal Derby Hospital site, wards 1 and 2 and the Dovedale Day Hospital on the London Road Community Hospital site. This was because these services are provided by a different NHS trust.

## Our inspection team

Our inspection team was led by:

**Chair:** Jan Ditheridge, Chief Executive, Shropshire Community Health NHS Trust.

**Team Leader:** Carolyn Jenkinson, Head of Hospital Inspection, Care Quality Commission

The team of 35 included CQC inspectors and a variety of specialists; a medical consultant, a surgical consultant, a

consultant obstetrician, a consultant paediatrician, a consultant anaesthetist, a junior doctor, board-level nurses, modern matrons, specialist nurses, theatre nurses, an emergency nurse practitioner, a supervisor of midwives, student nurses, a paramedic and two experts by experience.

## How we carried out this inspection

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

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

## Detailed findings

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group, NHS Trust Development Authority, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the royal colleges and the local Healthwatch organisations.

We held a listening event in Derby on 8 December 2014, when people shared their views and experiences of both hospitals. Some people who were unable to attend the listening events shared their experiences by email or telephone.

We carried out an announced inspection visit from 8 to 11 December 2014. We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, junior doctors, consultants, midwives, student

nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

We talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment. We also carried out an unannounced inspection on 22 December 2014 of accident and emergency, critical care, medical care and surgery.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Royal Derby Hospital.

## Facts and data about Royal Derby Hospital

Derby Hospitals NHS Foundation Trust provides both acute hospital and community-based health services, serving a population of over 600,000 people in and around Southern Derbyshire. Twenty percent of the population is made up for ethnic minorities. The trust runs two hospitals, the Royal Derby Hospital and London Road Community Hospital. Acute services are from the Royal Derby Hospital, which opened in 2010, and includes the Derbyshire Children's Hospital. The site has a rooftop helipad. Community and rehabilitation services are run from London Road Community Hospital.

The city of Derby has a deprivation score of 63 out of 326 (1 being the worst). Deprivation measures show that Derby Unitary Authority has a significantly deprived population, and is worse than the national average on a range of population health measures. South Derbyshire and Derbyshire Dales have less deprivation and better public health outcomes in comparison.

The trust employs 8,779 staff; 782 medical 2,191 nursing and 3,680 other staff.

# Detailed findings

## Our ratings for this hospital

Our ratings for this hospital are:

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

### Notes

<Notes here>

# Urgent and emergency services

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

## Information about the service

The emergency department at the Royal Derby Hospital provided consultant-led emergency care and treatment 24 hours a day, seven days a week to a population in excess of 600,000 within Southern Derbyshire. A roof top helicopter pad enabled patients to be transported by air ambulance to access rapid medical attention. There was a separate co-located children's emergency department led by consultants from the paediatric business unit within the hospital. Last year 119,186 patients attended the adult emergency department, and 32,000 patients attended the children's emergency department.

During our inspection, we spoke with 24 patients, 12 relatives or carers and 37 staff members. We looked at 11 records of care and treatment. As part of our inspection we used the Short Observational Framework for Inspection (SOFI) which is a specific way of observing care to help us understand the experience of people who could not speak with us. We also reviewed information from comment cards that were completed in the waiting area.

## Summary of findings

The adult and children's emergency departments at the Royal Derby Hospital were safe. Reliable systems and processes were in place to promote safe care and emergency preparedness plans were in place. Patients received care and treatment based on best available national evidence-based standards and guidelines. Effective and consistent levels of care were available 24 hours a day, seven days a week.

Patients and relatives were all positive about the care they had received. Staff offered care that was kind, respectful and considerate. They responded to patients' anxiety or distress with compassion and offered emotional support.

The department was not consistently meeting the four hour waiting time target for emergency departments. However, staff in the department were leading work within the wider trust to support improvement in this area. The department was dealing with unprecedented demand at the time of our visit, but there was always calm and a clear sense of purpose amongst the staff team. Leadership and management of the emergency department focussed on the delivery of high-quality, person centred care. There was a positive culture with a strong team ethos and consultants in the department were approachable, committed and passionate about continuous improvement.

# Urgent and emergency services

## Are urgent and emergency services safe?

Good



The adult and children's emergency departments were safe. Incident recording and reporting was effective and action was taken to improve practice and patient experience.

There were reliable systems and processes to promote safe care. These included approaches to infection prevention and control, cleanliness and maintenance of equipment, as well as the safe management of medicines.

Staff recognised and responded to any deterioration in a patient's health and worked with others to prevent and respond appropriately to any signs or allegations of abuse.

Staffing levels were set to meet patients' needs at all times of day and night. Effective emergency preparedness plans were in place.

### Incidents

- The department had reported two serious incidents requiring investigation (SIRIs) to the Strategic Executive Information System (STEIS) for 2013 and 2014. We looked at the serious investigation reports from these incidents and saw that there had been full investigations. Learning from the incidents had been recorded along with agreed actions.
- Staff were aware of the trust's electronic incident reporting procedure and all hospital staff we spoke with, including the trust's security team, told us they knew how to report incidents and they received feedback from incidents they had raised.
- Agency staff told us that they did not have access to the online reporting system and therefore reported any concerns to a line manager who would assist them to complete the electronic form.
- We looked at minutes of mortality and morbidity meetings held for the children's emergency department and saw that all deaths were reviewed and discussed. Where appropriate learning was shared and actions taken. All bereaved families were also offered follow up appointments with a consultant.

- Senior managers told us that they held monthly mortality and morbidity meetings in the adult department.

### Cleanliness, infection control and hygiene

- The department was clean and staff were aware of the current infection prevention and control guidelines.
- Adequate hand washing facilities and alcohol gel was available throughout the department.
- We observed good practices, such as staff following hand hygiene, 'bare below the elbow' guidance, and wearing personal protective equipment such as gloves and aprons, whilst delivering care.
- 80% of departmental staff had received training in infection control against a trust target of 95%.
- Infection control audits were carried out in the department. Results of the most recent dated 4 November 2014 showed an overall score of 95% and actions were identified to improve the score for subsequent audits.
- Each audit we reviewed showed an improved score from the previous audit and actions for improvement were identified.

### Environment and equipment

- There were adequate supplies of suitable equipment. Appropriate life support and associated monitoring equipment, along with resuscitation equipment, was available and accessible within the department.
- There was a schedule for regular checks of this equipment.
- On two resuscitation trolleys we found that these checks had not been carried out to the required frequency. We brought this to the attention of the lead nurse who immediately carried out the necessary checks. Checks on all other trolleys were up to date.
- There was a safe and effective system in place for the repair and maintenance of equipment. However, we found one piece of out of date equipment on a resuscitation trolley on the adult emergency department observation ward (also known as ward 101). We brought this to the attention of the nurse in charge and this was immediately replaced.

### Medicines

- Medicines were stored, managed, administered and recorded safely and appropriately.

# Urgent and emergency services

- Qualified nurses manning the reception were working under a patient group direction (PGD) for the prescription of simple pain relief. Patient group directions provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines, such as painkillers, to a predefined group of patients without them having to see a doctor. We saw copies of these PGDs which were all correctly completed and authorised.
- Trust data showed that staff in the emergency departments had received training in medicines management.
- During our inspection we visited ward 101 in an evening when there were no patients admitted. The ward was not locked and the resuscitation trolley was accessible. Drugs on this trolley were also accessible as the trolley had a temporary seal for ease of access.

## Records

- We looked at 11 records of patient care and found that they were all completed in accordance with the trust's policy for the completion and maintenance of patient health records.
- Appropriate risk assessments had been completed, for example in relation to the risk of pressure ulcers. Regular observations and early warning scores were completed as required.
- Whilst visiting ward 101 in the evening we found multiple sets of patient records unsecured on a worktop at the rear of the nurse's station. We brought this to the attention of senior nursing staff and the records were immediately locked away. When we returned the following evening the notes were stored securely behind a locked door.
- On ward 101 we found a bag of confidential waste stored on the floor behind the nurse's station. This was moved to a secure location immediately when brought to the attention of senior nursing staff.
- Also on ward 101 we found one set of patient notes incorrectly included in records for a different patient. We brought this to the attention of a senior manager who immediately acted to rectify the error.

## Safeguarding

- Eighty-eight percent of staff had received training in safeguarding which was above the department target of 80%. All staff in the children's emergency department had received appropriate safeguarding children training.

- Policies and procedures were available to staff and they knew how to raise concerns regarding adults and children and they told us that they had received feedback from concerns they had raised.
- The hospital electronic records system alerted staff to children presenting at the department who were at risk of abuse.

## Mandatory training

- Staff received mandatory training in essential subjects such as safeguarding, infection control and medicines management. The department's completion rate for this training was 80%. Statutory training in patient handling, health and safety and information governance had been completed by 84% of staff.
- Each staff member had an electronic individualised training passport highlighting training required in red and training completed in green. Completion rates were kept under review.

## Assessing and responding to patient risk

- The minor injuries reception desk was staffed by a receptionist, a nurse and an advanced clinical practitioner to allow for prompt streaming of patients upon arrival within the department.
- Staff in the department used a recognised early warning score to show when a patient's condition was serious or deteriorating.
- For children, the department used a paediatric observation priority score (POPS). Staff were aware of the tools and how to escalate concerns regarding a patient. The patient records we looked at were filled out and scored correctly.
- All staff in the children's department were trained in advanced paediatric life support and triage. Once assessed as competent all staff could carry out an initial assessment of a sick child.

## Nursing staffing

- Nursing skill mix was appropriate. The department had a full complement of qualified nursing staff with a Band 7 Nurse in Charge and a Band 6 nurse in all areas to coordinate care. Staff patient ratios were 1:8 in the majors and 1:2 in resuscitation. There were fourteen registered nurses per shift across the department.
- Planned staffing levels were not always achieved in the adult department. Sickness absence of 5.59%, staff vacancies and maternity leave meant that levels were



# Urgent and emergency services

supplemented by use of the trust's own bank nursing staff and agency staff. All the bank and agency staff we spoke with had received an induction to the department. The department were actively recruiting to vacant nursing posts.

- There had been a formal review of nurse staffing in May 2013. The trust had identified the need to further review the nurse staffing levels because the numbers and the complexity of patients needing care was increasing. They had plans to review following the launch of national guidance on staffing levels in emergency departments.
- The trust had a 23% vacancy rate for health care assistants within the adult emergency department which was equivalent to seven vacancies. There were five vacancies for Band 5 qualified nurses. Senior managers told us that these posts were being recruited to and in the meantime were filled by bank staff.
- During our inspection we raised concerns about nursing staff levels in the emergency department observation ward which could accommodate up to six patients in three separate rooms. We discussed this with managers and they advised us that there was no acuity tool in place for this ward and no review took place of nursing staff numbers.
- We saw one trained nurse based on the ward to care for patients, support a ward round, answer the telephone and respond to call bells. We saw that it was not possible for one nurse to carry out all of these activities when the ward was full. We raised this concern with senior managers.
- Managers told us that the only flexibility they had around staffing was to take staff from other parts of the department to support ward staff but this could then potentially leave staff unsafe in other areas so preferred not to take this approach unless absolutely necessary. However, they did acknowledge our concerns and told us they had plans to review and increase staffing on the ward area.
- Nursing handovers took place at each shift changeover in a designated room. We observed three handovers where staff were advised where they were working and given any other relevant information. Information shared at handover was recorded in a communications book for future reference. The handover of individual patients took place in the department with medical staff also present.

## Medical staffing

- The departments employed a higher ratio of consultants and middle grade doctors, when compared to the England average but a lower ratio of registrars and junior doctors.
- The department employed advanced clinical practitioners (ACPs). These staff are trained to operate at a level similar to junior doctors and therefore reduced the impact of fewer medical staff at this grade.
- Medical staffing levels and skill mix were appropriate for the departments. There were 15 funded consultant posts in the adult department and 12 were filled at the time of our inspection. Locum doctors provided support to the children's and adults' emergency department to cover the vacant posts.
- The children's department had a vacancy for one consultant post. Discussions were taking place to decide how best to fill this vacancy including the possibility of a shared post with the adult department to increase flexibility of cover.
- Consultants were present in the adult emergency department from 8am to midnight and were available on call outside these times.
- In the children's emergency department consultants were present from 9am to 11pm Monday to Friday and from 1pm to 11pm at weekends. Outside of these times they were available on call.

## Major incident awareness and training

- The department had suitable major incident plans in place. Staff told us they had received training and that they took part in simulations. A consultant in the emergency department took the lead for plans in the event of a chemical, biological, radiological or nuclear (CBRN) incident. This is one category of emergency planning.
- During our inspection staff discussed the Ebola risk and told us about a new policy and plans for a table top exercise and simulation learning activity to enable preparedness for the presentation of patients with Ebola.
- A small team of three security staff were available 24 hours per day, seven days per week within the hospital. Nursing staff told us that security staff responded very



# Urgent and emergency services

quickly to requests for help and we saw an example of this. They also told us that staff would attend the department if there was potential for an incident and would assist with defusing the situation.

- Security staff told us they always responded to panic alarms within the department even if they had received communication that the alarm had been triggered in error. This was to ensure that staff were not under duress to state this.

## Are urgent and emergency services effective?

(for example, treatment is effective)

Good



Patients received care and treatment based on best available national evidence-based standards and guidelines.

Patients' needs were assessed appropriately and care and treatment was planned and delivered in accordance with their needs.

Staff were appropriately qualified and received regular relevant training and appraisal.

There was a multidisciplinary approach to care and treatment and staff worked with other health and social care providers to assess, coordinate and plan individual patient care and treatment.

Effective and consistent levels of care and treatment were available 24 hours a day, seven days a week.

Patients were involved in and supported to make decisions about their care and treatment.

### Evidence-based care and treatment

- Clinical guidelines were developed and referenced with associated National Institute for Clinical Excellence (NICE) Guidance and other nationally recognised standards. These were accessible to staff and we saw that they were used in patient records.
- The department had a robust pathway for the care of patients with sepsis.
- Patients with suspected hip fractures were treated in line with best practice.

- Care and treatment pathways for stroke patients were consistent with approved guidelines. Thrombolysis took place within the department during the daytime and was delivered by the stroke team. Out of hours a stroke nurse would attend the department from the ward. Where necessary this nurse had access to an on call consultant via video conferencing for support.
- The College of Emergency Medicine audits two standards whereby three types of patient groups should be reviewed by a consultant prior to discharge. These are adults with non-traumatic chest pain, febrile children less than one year old and patients making an unscheduled return to the department with the same condition within 72 hours of discharge.
- Results for these consultant sign off audits were as expected or better for five out of eight indicators. However, results for the review of department notes after discharge by consultants or senior doctors were worse when compared with other trusts in England.
- A consultant within the department took the role of audit lead. Junior doctors participated in departmental audit activity.
- Ambulatory care pathways were in place and followed by staff.

### Pain relief

- The adult emergency department reception was manned by qualified nurses. They undertook initial assessment and asked patients about their pain. If pain relief was needed the nurses were able to give appropriate pain relief under a Patient Group Direction (PGD).
- Patients we spoke with had been asked about their pain and given pain relief where appropriate upon arrival in the department and at regular intervals during their visit.
- Patients waiting in the children's emergency department had also received pain relief under a PGD from qualified nurses.
- Staff monitored patient's pain, responded appropriately and recorded the information in patient's records. Patients told us they had received appropriate pain relief and we saw children receiving analgesia whilst in the department.

### Facilities

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- Although the environment in the adult emergency department was modern and well maintained some corridor areas were cluttered with chairs, trolleys and equipment.
- Signage in the department was poor with no official welcome or clearly visible information available about waiting times at the reception for minor injuries. A manager showed us draft notices which they planned to display in each area of the department to inform patients.
- Televisions giving information to patients were located in the minors reception area and internal waiting area. The television in the reception area was not on during our announced and unannounced inspections. The second television was switched on and gave useful information to patients waiting.
- Information about facilities was not accessible to patients for whom English was not their first language, or to patients with cognitive impairments who would benefit from more pictorial information.
- Several patients told us that they had problems parking at the hospital and had to queue to wait for a space. One relative who had brought a patient into the department on the recommendation of their GP told us they had queued for 25 minutes to park. This had caused them anxiety knowing that the patient needed to be seen by a doctor.

## Nutrition and hydration

- We saw staff offered food and drinks to patients where appropriate and this was recorded in their records. We spoke with the housekeeper who confirmed that they ensured food supplies were available for the department.
- Staff told us that they completed a 'comfort round' every two hours where patients were offered drinks. We observed staff carrying out these comfort rounds and patient records included this information.
- Drinks were available within the adult and children's departments on a trolley which was accessible to patients and relatives.

## Patient outcomes

- The department participated in National College of Emergency Medicine (CEM) audits so they could benchmark their practice and performance against best

practice and other emergency departments. Audits included consultant sign off, vital signs in majors, renal colic, fractured neck of femur and severe sepsis and septic shock.

- We looked at the audit results and saw that they had been reviewed by managers and priorities for improvement had been identified. These priorities were displayed in the department and staff were aware of them.
- Consultant sign off data from the CEM 2013 audit showed the department performed about the same or better than the England average for five out of eight indicators.
- For three indicators performance was worse than the England average. A consultant within the department had reviewed the data and an action plan for improvement had been agreed with three out of four actions completed at the time of our inspection.
- The audit of patient's observations (CEM vital signs in majors audit) showed that the department achieved 100% compliance with each of the indicators for measurement of vital signs after arrival with the exception of temperature which was 96% compliance.
- Compliance with repeated and recorded observations within 60 minutes was at 25% against a target of 100% with temperature again lower at 22%. The department had plans in place to improve this result including staff education, a change in documentation and a review of an alternative thermometer to enable temperatures to be taken when access to a patient's ear was restricted.
- The renal colic audit results from 2012 showed that pain scores were recorded for 96% of patients against target of 100%. The administration of pain relief within appropriate timeframes was only achieved for one out of five indicators. Scores for the re-evaluation of pain were significantly below the standard.
- The department achieved the standard for appropriate investigations carried out in one out of five categories. These results had been audited and an action plan for improvement agreed.
- Fractured neck of femur audit results for 2014 showed an improvement on the previous audit results from 2012. However, targets for the administration of pain relief were still below the CEM standards for two out of three indicators. This meant that some patients were not getting pain relief promptly.
- 57% of patients received an x-ray within 60 minutes of arrival in the department against a standard of 75%.

# Urgent and emergency services

86% of patients were admitted within four hours of arrival against a standard of 98%. The audit had been reviewed and action plans were in place for further improvement.

- Results for the CEM severe sepsis and shock audit were within or above the range of results for other departments in England with the exception of two out of 13 indicators which were in the lower quartile of England average results. These related to the administration of oxygen and the measurement of serum lactate. We saw that these results had been reviewed and an action plan written. Feedback on this audit was on display in the department and prompts for the treatment of sepsis on display in the resuscitation area.
  - Re-admittance rates to the emergency department within seven days were consistently worse than the 5% target set by the Department of Health and up to 2% above the England average between May 2013 and May 2014. A senior manager told us about a project being led by a consultant within the department to review the reasons for frequent re attendance to the department and to aim for a reduction. This project was also being run in two other parts of the hospital from the end of October 2014. Senior managers also told us that each consultant reviewed re-admittance rates for their patients as part of their job planning and appraisal objectives.
  - Nursing and mental health staff told us about an increased number of patients attending the department with mental health conditions, including suicidal intent or the desire to self-harm. Records showed that attendances had increased by more than 50% since 2010. Between June and September 2014 there had been five incidents of self-harm in the department amongst this group of patients. The incidents and the risks had been analysed and the department had taken immediate action. The team had introduced a mental health risk assessment tool for patients at risk of self-harm (VISA). However, medical and nursing staff told us having the flexibility to increase nursing staffing levels for an identified one to one observation would be helpful. Currently one to one observations reduced staffing in other areas in the department.
- Children's department nurses were all trained in advanced paediatric life support.
  - Medical and nursing staff received appraisals. We saw records that showed that 90% of staff in the adult emergency department and 96% in the children's department had received an appraisal within the previous 12 months against targets of 90%. The appraisal was also an opportunity to identify training needs and set development objectives at personal and department level.
  - Health Education England visited the trust on 4 November 2014 and recorded that the department provided an excellent training environment and programme for all learners in emergency medicine. This included innovative work on human factors simulation training.
  - One consultant managed a learning notice board in a staff only area of the department where staff were able to access monthly feedback on learning from incident reporting, case summaries and minutes of departmental meetings.
  - The department offered multi-disciplinary clinical simulation training monthly.
  - Staff told us and we observed them rotate roles within the department half way through a shift. This meant that staff did not work in a challenging area for a full 12 hours and that they were able to maintain skills across all areas of the department. This included reception staff who were skilled to work in every area

## Multidisciplinary working

- Medical and nursing staff worked well together as a team and there were clear lines of accountability and leadership that contributed to the planning and delivery of patient care.
- We saw effective working with ambulance crews. The department used a pre-alert system where a computer screen identified when patients would arrive.
- Police officers attending the department told us that staff worked well with them.
- The trust had introduced a Frail Elderly Assessment tool which was used to screen elderly patients in the adult emergency department. The trust Frail Elderly Assessment Team including therapists, medical staff, social workers, mental health specialists and pharmacists was available between 8am and 8pm seven days a week.

## Competent staff

- Nursing staff were appropriately qualified and were trained in basic life support.

# Urgent and emergency services

- Their aim was to provide a comprehensive assessment of the patient and work with the wider community team to ensure that medically fit elderly patients could return home safely and where possible within the same day. This was achieved for an average of 80% of these patients between February and August 2014.
- Physiotherapy support was available to the department from 8am to 8pm.
- Mental health liaison services were available 24 hours a day. Emergency department staff told us that the service was good and responsive, usually within 30 minutes of any request..

## Seven-day services

- The emergency department was consultant led, offering a service 24 hours a day, 365 days a year.
- Consultants were present in the adult emergency department from 8am to midnight and available on call outside these times.
- In the children's emergency department consultants were present from 9am to 11pm Monday to Friday, from 1pm to 11pm at weekends and available on call outside these times.
- X-ray and CT scanning facilities were available 24 hours per day, seven days per week, adjacent to the emergency department.

## Access to information

- Staff were able to access all the information they needed to deliver effective care and treatment to patients. The department held a mixture of electronic and paper patient records.
- On ward 101 we found out of date information for staff on a number of topics including how to access an interpreter, documentation forms dating back to June 2000 and out of date emergency resuscitation guidelines from July 2003.

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

- We saw and heard all staff discussing care and treatment options with patients and their relatives to enable them to make informed choices.
- Where patients lacked capacity we saw that appropriate actions were taken to ensure that decisions were made in the patient's best interests and that these actions were recorded.

- We saw during our observations that staff sought consent from patients before undertaking treatments and that patient consent was recorded in the records we reviewed.

## Are urgent and emergency services caring?

Good



Patients and their relatives were all positive about the care they had received. Staff consistently offered care that was kind, respectful and considerate.

There were times when it was a challenge for staff to provide privacy and protect patients' dignity because of crowding in the department.

Staff involved patients and their relatives in decisions about their care and their choices and preferences were, where possible, acted on.

Staff responded to anxiety or distress with compassion and offered emotional support.

## Compassionate care

- During our announced inspection there was unprecedented demand on the adult emergency department. Despite the high numbers of patients staff remained calm, considerate and compassionate and they always made time for patient's needs.
- We observed positive interactions between staff, patients and their relatives. Staff consistently demonstrated caring attitudes towards patients, some of whom were particularly challenging because of their condition or a cognitive impairment. Staff behaved compassionately and respectfully at all times.
- We spoke with 24 patients and 12 relatives or carers. They told us that they had been treated with dignity and respect and had "no complaints whatsoever". Many patients told us of "excellent staff" and "excellent treatment". "Staff have made this as easy as possible". One parent told us, "Doctors here are exceptionally good".
- We observed staff carrying out numerous individual acts of kindness such as organising for the cancellation of

# Urgent and emergency services

home based care packages, arranging collection of a hearing aid for a patient who had been admitted without it and helping a patient to access television on their own electronic device.

- We saw a consultant taking a patient in a wheelchair to a ward. They said during busy periods, “It’s a small thing I can do and it makes a big difference”.
- During our Short Observational Framework for inspection observation, staff demonstrated genuine care and concern for patients.
- We saw staff pulling curtains around each patient’s bay and closing doors to individual cubicles to maintain patient’s privacy and dignity.
- We saw staff ensured that patient’s cultural and religious needs were taken into account, for example ensuring that religious dietary needs were met.
- When patients experienced physical pain, discomfort or emotional distress we saw staff responding in a compassionate and timely manner. We saw good examples of this for patients with a learning disability or living with dementia, who were supported to manage their anxiety.
- During our announced and unannounced visit to the department there were frequently up to eight patients waiting in the central space of the majors area as all the bays and cubicles were occupied. For these patients, staff had no means of providing privacy and we saw that basic observations such as blood pressures had to be taken within sight of other patients and relatives. Patients waiting in the ambulatory care area of majors were able to observe these interactions. Staff ensured wherever possible that patients waiting in public areas had been assessed and a decision to admit had been taken. Where necessary they moved patients into cubicles to offer privacy and dignity during treatment.
- The acute medicine business unit managers were aware of the ‘crowding’ risk in the department and a senior manager told us the lack of dignity for patients when the majors department was crowded was a concern.
- Between April 2013 and July 2014 friends and family test results were consistently better than the England average.
- In the Care Quality Commission Accident and Emergency Patient Survey of 2014 the department scored similar to other emergency departments in England for levels of care. This indicated that patient experiences of care were in line with current performance of care across England.

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

- During our Short Observational Framework for inspection observation we heard medical staff explaining care and treatment options to patients and those close to them.

## Emotional support

- We saw staff talking with patients and their relatives and responding to questions in an appropriate way. All staff gave responses, reassurance, comfort and emotional support to patients and relatives who were anxious or concerned.
- The hospital had a Faith Centre and chaplaincy services were based there. However, a member of the administration team told us the team would attend the department in response to requests to support patients and relatives.
- Play specialists worked in the children’s emergency department to support patients.
- A member of the mental health liaison team told us, “The attitude of staff is pretty good for mental health patients”.

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

Good



Staff in the department understood the needs of patients and had designed and delivered services to meet those needs where possible.

The department was not consistently meeting the four hour waiting time target for emergency departments, with an average weekly performance of 94.5%. However staff in the department were leading work within the wider trust to support improvement in this area. The department was dealing with unprecedented demand at the time of our visit, but there was always calm and a clear sense of purpose amongst the staff team.

Systems and processes were in place to receive, review and learn from complaints and compliments.



# Urgent and emergency services

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

- Attendances at the department had increased by 6% since 2013. The department was in the process of recruiting six additional nursing staff to care for the increased number of patients.
- Four months prior to our visit the children's emergency department had opened a six bedded observation ward within the department where children could be admitted under the care of the emergency team for a period of up to six hours. The ward was open from 7:30 am to 11pm seven days per week. This enabled continuity of care for patients requiring short term observation and avoided them being transferred to a ward, only then to be discharged soon afterwards.
- The adult department had a six bedded co-located observation ward (ward 101) where adults could be admitted for a maximum stay of 48 hours.
- Leaders in each of the different adult areas had recently been issued with armbands so that patients could recognise who was in charge.
- There were plans to display information about uniform colours to enable patients to understand the roles of staff according to the colour of their uniform.
- The department had recognised the specific needs of patients with mental health illness. In partnership with Derbyshire Healthcare NHS Foundation Trust they were able to provide 24 hour access to a mental health liaison team. This project was initially funded for one year.
- Due to an increasing number of frail elderly patients in the local community a specialist team of doctors, nurses, therapists and social workers known as the frail elderly assessment team (FEAT) were introduced to the department to promote same day discharge.
- Consultants had recognised an increasing number of patients attending the department because they were not registered with a GP. To address the needs of this group they had secured an agreement for a nearby practice to register these patients. The aim was to reduce the need for emergency department attendances.

## Meeting people's individual needs

- The children's emergency department cared for children up to the age of 18. Staff told us that they could be flexible regarding care and treatment for young people

aged 16 to 18 years. For example, we saw staff were responsive to the needs of individual young people by keeping them in the adult areas for treatment if this was more appropriate for their needs or age.

- The department had food bank vouchers which the nurse in charge was able to authorise for patients in need. Staff were reminded about the availability of vouchers during the nursing handovers.
- Patient information sheets were available for a wide range of injuries and illness. Whilst these were not available in public areas, staff routinely gave them out when required. However we observed that these were not available in many other languages or in an accessible format. A member of staff in the children's emergency department told us about plans for the introduction of a new computer based system which would allow staff to print patient information leaflets in different languages.
- Signs in the department were not translated into any other languages or displayed pictorially for ease of comprehension.
- A translation / interpreter service was available to patients and staff knew how to access this service and told us they had done so. They also told us they would sometimes use the support of staff within the hospital as interpreters. We saw examples of this during our inspection.
- A sign language service was available and staff told us that they could use video conferencing facilities to support patients with hearing impairment.
- A mental health liaison team based in the hospital provided assessment for patients within the department within one hour of a request 24 hours per day. This was a combined service for mental health, alcohol and substance abuse, initially for one year.
- We saw evidence that the adult department used the 'This is me' leaflet designed by the Royal College of Nursing and the Alzheimer's Society to understand the needs of attending patients living with dementia.
- The Trust had a Frail Elderly Assessment Team (FEAT) offering personalised care and support for this group of patients. This team focussed on ensuring patients were cared for in the community wherever possible. 80% of elderly patients attending the department were discharged home on the same day after being seen by.

# Urgent and emergency services

- The children's department waiting area was appropriately decorated and well equipped with toys and books for patients; however one parent told us that the facilities were more appropriate for younger children.

## Access and flow

- The Department of Health target for emergency departments is to admit, transfer or discharge 95% of patients within four hours of arrival at A&E. Between July 2013 and July 2014 the department regularly saw 95% of patients within this timeframe. There were periods where performance dropped to between 90 and 95%. Average weekly compliance with the standard for 2013/2014 was 95.4%. Average weekly compliance for the calendar year 2014 was 95.5% which was just above the national target.
- The average total patient time in the emergency department between May 2013 and May 2014 was less than 160 minutes. This was worse than the England average which was less than 140 minutes. At the time of our inspection the adult department was experiencing unprecedented demand. On one day, 452 patients were treated within the department. This was 100 more than would normally be expected. On this day every patient was seen, treated, admitted or discharged within the four hour standard target.
- Senior managers told us that the four hour target was viewed at the trust as a system wide target.
- An emergency department consultant had carried out research on the link between achieving the target and hospital bed occupancy figures. This research had been taken further to establish a link between medical bed occupancy and hospital mortality rates.
- As a result, the trust had introduced a trust wide strategy to support reduced bed occupancy, improved results for the four hour emergency department standard and reduced Hospital Standardised Mortality Rates (HSMR). This work had resulted in a 94.5% average weekly compliance with the four hour standard in 2013/14 compared with 92.5% average weekly performance in 2012/13.
- Between September 2013 and September 2014 less than 8% of patients admitted to hospital via the emergency department waited between four and 12 hours for a bed on a ward. The trust had no 12 hour

waits from decision to admit to admission. This means that all patients were transferred to a hospital bed within 12 hours of a doctor deciding they needed hospital admission.

- On average, less than 2% of patients left the department without being seen during the period May 2013 to May 2014. This was significantly better than the England average performance for this standard.
- Ambulance crews told us that handovers were generally good. Between July 2013 and July 2014, 100% of patients arriving by ambulance had received an initial assessment within the 15 minute target.
- Since January 2013, the trust had consistently performed significantly better than the 15 minute standard for initial assessment of patients arriving by ambulance.

## Learning from complaints and concerns

- Between June and December 2014 the department had received 48 complaints. The majority were about care provided, attitude of staff and communication.
- Systems and processes were in place to advise patients and relatives on how to make a complaint
- Information was not displayed within the department and leaflets were not available to patients unless they asked for them.
- Staff were aware of how to manage complaints and how to support patients who wished to complain.
- Concerns and issues arising from complaints were discussed at the monthly acute medicine business unit risk steering group meetings. However we did not see any evidence of lessons learnt or action plans as a result of complaints.

## Are urgent and emergency services well-led?

Good



Leadership and management of the emergency department focussed on the delivery of high-quality, person centred care and supported learning.

There was a positive culture with a strong team ethos and good relationships between nursing and medical staff.

# Urgent and emergency services

Consultants in the department were approachable, committed and passionate about continuous improvement.

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

- The consultant team in the department were passionate about the service and committed to their vision for improvement. They and other staff spoke of doing things “The Derby Way” and of caring for patients with mental health conditions being “in their DNA”.
- Senior managers told us about a transformation strategy for urgent care which included work across the health economy and had begun 18 months previously. This included a focus on ambulatory care pathways and building links with community health providers.

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

- Senior managers were able to identify the top risks within the department including overcrowding in the department, meeting the four hour target and caring for patients at risk of self-harm. There were plans in place to monitor and address these risks.
- The acute medicine business unit risk steering group met monthly. These meetings were led by a consultant, supported by administration staff and attended by nursing and medical staff. The agenda covered a range of issues including learning from complaints, compliments, and incidents, risk and audit updates and feedback from inquests or litigation. We saw the minutes for these meetings with actions identified.
- Weekly senior nursing manager meetings were held in the department to discuss staffing and sickness, training and service development. The matron for the business unit completed a quality report which was placed on a shared drive for all senior sisters to contribute to and access to follow up action plans.
- Senior managers met every four months for a quality and performance review meeting.
- The leadership team within the children’s emergency department maintained a risk register which was up to date and regularly reviewed.
- The risk register for the adult emergency department required updating. However, we saw in the minutes of the Acute Business Unit Risk Steering Group Meeting of 12 November 2014 this had been noted.

## **Leadership of service**

- The adult department was led by a Clinical Director, Matron and General Manager.
- Without exception staff we spoke with told us this was a good department with excellent and approachable consultants offering solid support.
- Several staff told us about a ‘back to the floor’ initiative every Friday where the executive team carried out front line roles.

## **Culture within the service**

- There was a positive culture within the department; staff shared their views openly and constructively. Medical and nursing staff were committed and enthusiastic about the department and worked very well together to ensure that patients were given the best care and treatment possible.
- A member of the administrative team told us, “Patient care and communication here is excellent. It’s a good team; not just a department”.
- All staff we spoke with told us they felt valued by the team and well supported, including bank, agency staff and volunteers who told us, “I cannot speak highly enough of this department”. Student nurses talked about being well supported and treated with kindness and respect.

## **Public and staff engagement**

- Patient feedback forms were available in the reception area for patients to complete.
- Computer screens when locked displayed rolling messages about important information for staff including reminders about patient privacy, updated care pathways and winter pressures information.
- Healthwatch had recently completed an Enter and View visit to the department and published a report.
- “Pride of Derby Awards” where patients, relatives or staff were able to nominate staff members were displayed in the department to acknowledge the work of staff.

## **Innovation, improvement and sustainability**

- The department offered a Certificate of Eligibility of Specialist Registration (CESR) rotation in emergency medicine. CESR is a means by which doctors who have not completed an approved deanery training programme can be entered on the Specialist Register. It is a competency-based process where the trainee



# Urgent and emergency services







provides a portfolio of evidence that demonstrates that their training, qualifications and experience meet the requirements of the Emergency Medicine CCT curriculum.

- Successful completion of the CESR process results in entry onto the Specialist Register and the doctor is then able to apply for Emergency Medicine Consultant posts in the traditional way. This initiative enabled the department to recruit a high number of middle grade doctors at a time of national shortage.
- The consultant lead for this project had been nominated for an NHS East Midlands Emergency Management Leadership Academy NHS Recognition Award as Development Champion of the Year.
- An emergency department consultant had carried out research on the link between achieving the four hour

standard for emergency patients and hospital bed occupancy figures. This research had been taken further to establish a link between medical bed occupancy and hospital mortality rates. As a result of this research the trust had introduced a trust wide strategy to support reduced bed occupancy, improved results for the four hour emergency department standard and reduced Hospital Standardised Mortality Rates (HSMR).

- Trauma simulation training within the department was coordinated by a lead consultant and organised monthly at varying times to allow for attendance across the shifts. Following the sessions debriefing took place and learning was recorded and shared and improvements made.

# Medical care (including older people's care)

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

## Information about the service

Royal Derby Hospital medical care services were managed by the directorates of medicine and cancer. Specialties included: general medicine, haematology, oncology, hepatology, gastroenterology, respiratory medicine, cardiology, endocrinology, nephrology and stroke. Geriatric medicine and rehabilitation were managed by the directorate of integrated care.

There were 447 medical inpatient beds, 84 elderly care medicine beds, 39 rehabilitation beds and 120 day case medical beds available.

During 2013/2014, there were 55,163 medical inpatient admissions to the Royal Derby Hospital.

Patients were admitted to the medical assessment unit (MAU) on a short stay basis after direct referral from their GP, or from the emergency department. Patients were either discharged directly from MAU or transferred to another short stay or specialised ward within the hospital.

We visited 14 wards, the MAU, discharge lounge, coronary care unit, catheter laboratory, endoscopy unit. We spoke with 63 patients/relatives and 116 staff. We observed staff interacting with patients, this included a short observation framework for inspectors (SOFI). A SOFI is a structured observation tool, which enables inspectors to record interactions with patients with dementia who are unable to communicate and the impact of the interactions over a specific time period. We spoke with staff and looked at records.

## Summary of findings

Medical and nursing staffing levels generally met the required standard. However there were some occasions where the actual number of registered nurses fell below the required number. A need to recruit further staff in these areas had been identified by the trust.

There were suitable arrangements to identify and manage risks, and to monitor the quality of the service provided. There had been a reduction of the number of patient harm incidents such as pressure ulcers and ward-based falls.

Staff told us they were encouraged to report safety incidents and they received feedback. Care was provided in line with national best practice guidelines. The trust has had mixed performance in comparison with other hospitals which provided similar types of treatment. We observed all levels of staff demonstrating a caring attitude towards their patients, treating them with dignity and protecting their privacy.

# Medical care (including older people's care)

## Are medical care services safe?

Requires improvement



Overall, we judged this service as requiring improvement. Most wards had sufficient and appropriate medical and nursing staff. However, there were nursing staff shortages in the acute stroke ward and MAU. We found that staff shortages were impacting on ward and unit performances and we found that this could compromise patient safety. A need to recruit further staff in these areas had been identified by the trust.

There had been improvement in the number of patient harm incidents, such as pressure ulcers and ward-based falls.

The ward and patient areas were clean and tidy. We saw hand hygiene policies adhered to, and staff wore protective clothing when required. Infection control policies and procedures were mostly followed, although there was a need to ensure that single use equipment was not reused.

Resuscitation trolleys were accessible on each ward and had been checked and signed as 'in order' on a daily basis, as per trust policy. There was a need to ensure that patient lifting and bathing equipment was appropriately serviced to ensure patient safety.

### Incidents

- There were systems for reporting actual and near miss incidents across the medicine and elderly care division. Learning from incidents was discussed during team meetings, shared via email and lessons learned information was displayed on notice boards in staff areas.
- Staff told us they were aware of how to report incidents and were encouraged to do so. Staff told us that they received feedback on the incident and gave examples of when practice had been improved.
- The trust reported one Never Event within medicine in the period January to October 2014. Never Events are serious, largely preventable patient safety incidents that

should not occur if the available preventative measures have been implemented within medicine. We saw that an investigation had been undertaken and an action plan was in place to ensure that lessons were learned.

- The trust investigated every serious incident through a root cause analysis investigation process and an action plan for improvement was identified; 89 serious incidents were reported for the Royal Derby Hospital for the medical division..
- Mortality and morbidity meetings were held monthly and were attended by representatives from all teams within the divisions. During those meetings attendees reviewed the notes for patients who had died in the hospital within the previous month and, when needed, actions were taken to improve practice.

### Safety Thermometer

- Information about the incidence of pressure ulcers, infections and falls with harm was prominently displayed on all the medical wards and units we visited. The information identified the number of days since the last pressure ulcer, falls with harm and infection rates. Information was shared with ward managers about the performance of their ward and, when required, actions needed to improve performance.
- For the period July 2013 to July 2014 the number of medical patients with pressure ulcers, suffering from falls and with catheter-acquired urinary tract infections (CUTIs) had improved.

### Cleanliness, infection control and hygiene

- The wards we inspected were clean and well maintained.
- There were signed cleaning schedules and labels on equipment showing when cleaning had last taken place.
- Each ward we visited had a housekeeper who checked on general cleanliness and availability of equipment.
- Staff adhered to the trust policies for hand hygiene, personal protection equipment (PPE) and isolation. Hand washing facilities and hand sanitising gel was sited at ward entrances and throughout the wards.
- Monthly hand hygiene audits were undertaken. Results ranged from 90% to 100% compliance.
- Side rooms were used where possible as isolation rooms for patients identified as being an increased infection control risk (for example, patients with MRSA).

# Medical care (including older people's care)

There was clear signage outside the rooms so that staff were aware of the increased precautions they must take when entering and leaving the room. These rooms were also used to protect patients with low immunity.

- There were 16 cases of *Clostridium difficile* within the division of medicine and cancer in 2014/2015 and 17 cases in 2013/2014, which was above the trusts target. Information provided by the trust showed that a root cause analysis (RCA) investigation had been undertaken and when necessary actions were taken.

## Environment and equipment

- We saw that patient areas were free from trip hazards to ensure their safety. Wards appeared tidy and organised.
- Resuscitation equipment on all of the wards was checked regularly appropriately packaged and ready for use.
- We saw two single-use enteral syringes (a syringe used to administer nourishment and medication via a feeding tube) that had been used and left in their packaging on patient bedside tables on the acute stroke unit. These syringes should have been disposed of in clinical waste bins. We reported these to a nurse who told us, "We reuse syringes except for when patients have PEGs placed". We highlighted that the syringe packages stated single use only. The syringes were then disposed of. The practice of reusing single use items went against the trust's policy.
- We saw that patient lifting and moving hoists had not been serviced when required on four different wards. There were up to three hoists on each ward and they had not been serviced since May 2013. Hoists should be checked and serviced at least every six months to ensure they were safe for use. We were told that service records were not kept on site but were managed by an external company.
- The wards and areas we visited were well maintained. However, some wards had insufficient storage areas which led to equipment being stored inappropriately in bathrooms. This meant the bathrooms were difficult to access and were rarely used.

## Medicines

- Medicine cupboards and trolleys were appropriately locked. Medication administration record charts (MAR) were completed correctly.
- Medicines were stored appropriately, including those medicines which required cold storage. Records showed

that medicines were kept at the correct temperature, and so would be fit for use. We also observed that controlled drugs were stored and managed appropriately. We found that intravenous fluids were mostly stored safely and appropriately, although this was not the case on wards 401, 405, 406 and 409.

- Emergency medicines were available for use and there was evidence that these were regularly checked.
- The hospital used an electronic prescribing and medication administration record system for patients which facilitated the safe administration of medicines.
- Our pharmacist looked at the prescription and medicine administration records for 24 patients across six wards. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed people were getting their medicines when they needed them. If people were allergic to any medicines this was recorded on their electronic prescribing and medication administration record.
- A hospital pharmacist visited all wards each weekday. Pharmacy staff checked that the medicines patients were taking when they were admitted were correct and that records were up to date. Medicines interventions by a pharmacist were recorded on the system to help guide staff in the safe administration of medicines.
- Pharmacy input was available on site 24 hours a day. There was a top-up service for ward stock and other medicines were ordered on an individual basis. Staff reported that there was an effective on-call service, out of hours. This meant that patients had access to the medicines they needed.
- MAU had pharmacists on the ward for 12 hours each day, seven days a week. They worked as part of the frail elderly assessment team (FEAT) optimising the use of medicines, conducting medicine use reviews to reduce poly-pharmacy (inappropriate or excessive use of medicines); counselling patients at discharge and linking up with patients' home community pharmacists to ensure they were followed up after discharge. The overall aim was to help patients make the most of their medicines. We identified that this was an area of outstanding practice.
- When we visited MAU we found one patient was not receiving their required treatment, despite being on the

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unit for more than two hours. The patient had nebulisers in place but the oxygen they required was not connected. We reported this to nursing staff who then connected the patient to the oxygen as prescribed.

## Records

- The medical wards used a combination of computerised and paper records. We were told that electronic records were to be further developed to enable more information to be held in this way. Records were completed and filed in a consistent manner to enable staff to easily locate required information about the patient and their treatment and care needs.
- Medical notes were mostly stored in trolleys in secure rooms when not in use. We observed on more than one occasion that medical notes on trolleys in MAU were left unattended and not secure. This meant that confidential patient information may be accessed.
- We found that on MAU three of the six patients records we looked at did not have a completed care plan or risk assessments completed. The nurse in charge of these patients told us that they had been very busy all shift and all care records would be fully completed before they went off shift.

## Safeguarding

- The trust had policies and procedures in place for safeguarding children and vulnerable adults.
- The mandatory training records for the medical division showed that 92% of all staff had received safeguarding training.
- Staff we spoke with were aware of their responsibilities regarding safeguarding patients and actions they should undertake and knew how to access the policies and procedures on the trust's intranet.

## Mandatory training

- Training information provided by the trust showed that 93% of staff in the medical division had completed mandatory training.
- Staff confirmed that they received annual mandatory training in areas such as infection control, moving and handling and medicines management.
- Staff training and attendance was monitored by the ward manager and senior managers.

## Assessing and responding to patient risk

- The hospital used a scoring system referred to as the National Early Warning Score (NEWS) to identify deteriorating adult patients. There was a plan for this information to be highlighted electronically to the patients' doctors and nurses in charge. However, at the time of the inspection the nurse in charge had to speak to medical staff about acutely unwell adult patients. The development of the electronic records will provide greater assurance that the patients whose conditions are deteriorating will be provided with timely and appropriate treatment.
- Nursing handovers occurred at least twice a day with additional 'safety huddles', during which staff communicated any changes to ensure that actions were undertaken so as to minimise the risks to patients.
- Risk assessments for patients for pressure ulcers, falls and venous thromboembolism (VTE) were being completed appropriately and reviewed at the required frequency. Risk assessments identified required actions to minimise risks to patients.

## Nursing staffing

- In 2014, the Safer Nursing Care Tool was used within the trust to review patient acuity, dependency and staffing in all inpatient areas. As a result of this review, changes to the nursing establishment in adult inpatient wards were recommended and actioned in some areas.
- Wards displayed a staff information board, which showed the daily planned and actual number of staff (registered nurses and care staff) on each shift. We observed that most, but not all wards/units had the required nurse complement and skill mix. According to the information boards, we saw that, mostly, the numbers of staff on duty were correct, but on the MAU and the stroke unit we found a healthcare assistant would be on duty in place of a qualified nurse.
- The staffing levels on the MAU were calculated using a recognised tool and the numbers of registered nurses had increased in 2013. There were occasions when the number of registered nurses per shift dropped below the planned level. In such cases, the nurse would be backfilled with a health care assistant. In December 2014 20% of the registered nurse shifts did not have the planned levels of registered nurses and were back filled by healthcare assistants. Ward leaders found this challenging because of the level of complexity on the unit. There was an escalation process in place for the ward staff to flag if the staffing levels fell below a safe

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level and there had been no red flag alerts in November or December 2014. Despite the staffing issues, the rate of harm free care on the unit was 100% meaning that the patients did not come to harm from things like pressure sores or developing a blood clot.

- The hospital provided acute treatment for relevant patients on the acute stroke ward. Ward sisters told us about their concerns regarding staffing arrangements, particularly when staff had to leave the ward to assess acute stroke patients in the emergency department. We were told by the managers of the service the nurse in charge could be taken away from the ward between the hours of 19.30 and 07.30 to attend the emergency department to support any patient who required thrombolysis. Thrombolysis is a treatment given to patients who have had a stroke in order to break up the blood clot. This could take them away from the ward for approximately an hour and it occurred around five times a month. This was accounted for when the nursing establishment was calculated.
- We found there were times when the staffing levels were not as planned. The unit had gone through a period where there was a high rate of staff sickness. In December 2014 there were four registered nurse vacancies and the sickness level was almost 10%. Like on the MAU, where registered nurses could not be found to cover gaps in the planned staffing, healthcare assistants were used. We looked at the ward assurance data for the period June to December 2014. With the exception of December, the ward assurance scores were all over 97%, with four out of the seven months showing 99% compliance. The scores in December 2014 had dropped to 88%.
- The coronary care unit had received an increase in nursing staffing during 2013 following an assessment using a recognised acuity tool. The nursing workforce on the CCU also supported the Percutaneous Coronary Intervention service (PCI). PCI is an emergency treatment for patients who are having a heart attack and is a procedure where the arteries are stented or the clot is removed. Between 8am and 8pm, emergency nurse staffing support was provided by the catheter laboratory. Between 8pm and 8am emergency care was provided by the coronary care nurses. Staff told us they were concerned about the staffing levels on their unit and the impact of having to provide cover for other areas. There were vacancies on the unit as well as a sickness rate of almost 9%. We saw evidence that red

flags were triggered twice in December 2014 and steps were taken to assist the unit leaders to manage the staffing situation. When the red flags were escalated there was a nurse to patient ratio of one nurse to five patients which the trust considered was appropriate to the level of care needed by patients at that time.

- The trust confirmed that in October 2014 they recruited 66 newly qualified nurses and had planned to recruit a further 11 graduate entry nurses in January 2015
- Three patients commented that they thought wards were short of staff and that staff were too busy to help them. One patient felt that their ward was "A little short staffed" and other patients commented that they "... could do with more staff for toileting and feeding", and wards were "Understaffed at times." One patient told us that their family member had escorted them to the toilet because staff were "too busy".
- Three patients were concerned about the skills mix of staff. A patient said that they felt there were "too many HCA's (healthcare assistants) who can't do medical tasks". Another patient told us that they asked for pain medication and were told by a staff member: "I can't, but I will get someone to get you some." No one did."
- Two patients also witnessed the venting of frustration publicly by staff because they were so busy. One incident was reported to staff and was dealt with quickly by the nurse in charge. One patient reported a health care assistant being 'snappy' with them "because they were having to do everything".

## Medical staffing

- The medical staff skill mix had worse than the national average of registrar/ middle grade doctors (31% compared to 45%). However the trust had more than the national average for consultant posts (41% compared to 33%) to ensure that there were sufficient and experienced doctors available. The hospital also had better than the national average of then junior doctor roles (27% compared to 22%).
- Doctors of all grades were positive about medical staffing arrangements. Doctors told us that there were plans to further develop medical services and more consultants were to be employed.
- Junior doctors were positive about the support they received from more senior doctors.



# Medical care (including older people's care)

- All medical admissions were seen initially by a consultant or registrar in MAU and by a consultant within 12 hours of the patient going to a ward. This meant that patients received appropriate review by a senior doctor.
- There was at least one consultant available in the MAU between 7.30am and midnight Monday to Friday and from 7.30am up to 10pm Friday, Saturday and Sunday and up to 9.30pm on bank holidays.
- There were appropriate and sufficient registrar/middle-grade doctors on duty between 10pm and 8am for MAU, coronary care, elderly care and the medical wards. In addition, consultants were on an on-call rota and could be contacted for advice, or to come into the hospital when needed.
- Medical handovers varied from ward to ward, took place formally and informally throughout the day.
- The trust had appropriate arrangements in place to ensure that medical outliers (outliers are patients on wards of a different specialism such as medical patients on surgical wards). Non-medical wards had a 'buddy' consultant whom they contacted to review patients. Staff told us these arrangements worked well and patients were seen appropriately by doctors.

## Major incident awareness and training

- The trust had a major incident plan and business continuity plan. The major incident plan identified different types and levels of incidents and responses required by the hospital's staff. Staff we spoke with were familiar with their role within the major incident plan.
- The trust had identified a range of winter pressure plans. This included ensuring that patient flow was proactively managed by a central team which included representatives from the medical division and medical admissions unit, the use of the virtual ward in the community and additional winter pressure beds.

## Are medical care services effective?

Good



The trust performed better than the national average in the heart failure audit and Sentinel Stroke National Audit Programme (SSNAP) for October 2013 to March 2014. Improvement was needed to improve diabetic care within the hospital.

Patients had adequate pain relief and appropriate provision for fluid and nutrition intake. Staff were competent to carry out their roles. However there was a need to increase the number of nurses who had specific training in coronary care nursing. Clinical competencies and training were available for staff to develop. There was good multidisciplinary working within the acute stroke unit and most services were actively working towards seven-day working to meet patient needs.

## Evidence-based care and treatment

- Standardised relative risk of readmission for both elective and unplanned admissions were worse than expected for medical specialities which included general medicine, oncology, clinical haematology, gastroenterology, cardiology and nephrology. Clinicians were reviewing his information to assess if any improvements could be made.
- We observed that the discharge lounge proactively ensured that patients had all required assessments, medication and follow up arranged before they were discharged. We observed that staff completed audit data which showed the length of time the patient had been in the discharge lounge and the number of additional hours that this had freed up beds on the wards. We observed that the discharge lounge provided an effective service.
- There were guidelines on the intranet for the out-of-hours management of minimally symptomatic adults with newly diagnosed type one diabetes for staff to refer to when the diabetes specialist nurses were not available.
- Audits were undertaken three times a month to check staff compliance with 'aseptic non-touch technique' (ANTT), to reduce the risk of cross infection.

## Pain relief

- We heard positive feedback from patients about their pain control. Patients told us that staff regularly checked if they were in pain and needed any pain relief.[WD1]
- We saw nurses ask patients if they were in pain and, when needed, they ensured that pain relief was provided.

## Nutrition and hydration

- The majority of patients told us the food was generally tasty and presented well. Comments included: "I like the food – very good", and "lovely", and "[the] catering is

# Medical care (including older people's care)

very good" and "excellent". Two patients told us they disliked the food. Patients told us there was a good choice of food and their nutrition needs were being met. For example, a patient told us that the hospital provided a "good choice" of gluten-free food. Another patient described how the hospital served them pureed food.

- Dieticians supported and advised ward staff on patient care for diseases, such as diabetes.
- Nutrition assistants supported patients to eat and drink on the wards.
- Clinicians took advice from dieticians in developing diagnoses of nutritional problems. They provided individualised dietetic intervention using their expertise in food, nutrient, drug interactions, enteral feeding and counselling skills.
- They were protected meal times on medical wards.
- The red tray system was used to alert staff to support patients requiring assistance with their diet.
- Nutritional risk assessments were in place for some patients. We saw food charts completed that patients confirmed were accurately recorded.
- We saw fluid balance charts in place. We saw that the 'offered' and 'actual' fluid intake was recorded accurately, reflecting a patient's exact fluid intake.
- We audited whether patients had a drink within their reach on MAU and found that two out of five patients could reach a drink.

## Patient outcomes

- The trust had implemented hourly care rounds, which was a formal checklist used by staff to check patients every hour, for basic care needs such as assisting to use the toilet and having enough to drink. We found this promoted hourly staff to patient contact, and patients told us they liked this. However, we saw that hourly care rounds were not always recorded on the care plan. For example, on MAU there was no documentation for three hours for one patient in the past five hours. We asked nursing staff about this, they reported sometimes rounds were not always documented but other times they were too busy to complete rounds.
- The trust submitted data to the sentinel stroke national audit programme (SSNAP) which aimed to improve the quality of stroke care by auditing stroke services against evidence based standards and national and local

benchmarks. SSNAP is pioneering a new model of healthcare quality improvement through near real time data collection, analysis and reporting on the quality and outcomes of stroke care.

- During October 2013 to March 2014 SSNAP scored the hospital at level D (the lowest score possible is E). The audit identified poor results in speech and language therapy availability. An improvement plan for 2014/2015 was in place.
- The trust submitted data to the heart failure audit for 2012/2013. The audit identified that the trust performed better in eight of the 11 outcomes compared with other trusts in England and Wales. The audit identified that 98% of patients received input from a specialist, compared with the national average of 78%. Of these, 71% had input from a cardiologist, compared with the national average of 57%. Improvement was required to ensure that patients received appropriate further medicines when they were discharged home.
- The hospital provided emergency treatment for patients who are having a heart attack. Between April and September 2014, 91.5% of patients received emergency treatment within 90 minutes of attending the hospital. This was sometimes referred to as 'door to balloon time'. This is comparable with other hospitals providing similar treatment.
- Intelligence systems identified an increase in the number of deaths at Royal Derby Hospital in February and March 2014, from 'coronary atherosclerosis' and other heart disease. This was called a mortality outlier. An investigation was undertaken which identified a need to ensure improvements in coding and documentation.
- The trusts Summary Hospital-level Mortality Indicator (SHMI) and the Hospital Standardised Mortality Ratios (HSMR) mortality measures show the trust as being within expected limits between August 2013 and July 2014. SHMI and HSMR are ways in which the NHS measures healthcare quality by looking at the rates of mortality in the trust.
- The 2013 National Diabetes Inpatient Audit found that the Royal Derby Hospital performed worse than other trusts in 12 of the 21 areas assessed. The trust had acknowledged a need to improve diabetic care and an improvement plan was in place. Actions undertaken had



# Medical care (including older people's care)

included improved diabetes training for nursing staff, a review of the use of diabetes medicines and the improved assessment of diabetic patients to promote their health and wellbeing.

- The National Cancer Patient Experience Survey 2013 showed that 66% of patients found it easy to contact their clinical nurse specialist. The trust was in the bottom 20% of all trusts for this question.
- In the MAU between 10am and 6pm a health care assistant with qualifications in caring for patients who were living with dementia was available to assist patients in the FEAT lounge. One positive effect was that medical staff could assess the patient more quickly and thoroughly and their stay in MAU was shorter. Other nursing staff said that when this staff member was on duty they were able to spend more time with other patients.
- The average length of stay for elective and non elective patients across the trust was slightly worse than the national average. This meant that patients were staying in hospital longer than in other hospitals around the country. A mortality outlier alert relating to deaths due to 'coronary atherosclerosis and other heart disease' for the trust was identified in December 2014. The trust had identified that statistical information was incorrect and the alert should not have been made. The trust had accepted a previous alert in 2013, but said that there has been no increased risk for the 15 months before the inspection.

## Competent staff

- Staff told us they had received informal supervision in the form of team meetings and occasional one-to-one meetings with the ward manager. Staff told us that the senior staff were supportive and available to discuss any concerns. They felt listened to and valued.
- Staff told us that they could access their own education and training via the trust's intranet. The education programme identified both mandatory and development training that was available. Staff were able to book on to the training courses to develop their knowledge and skills
- National standards require that 50% of nursing staff working in coronary care have an additional qualification in coronary care nursing. Thirty six per cent of staff working in the unit had this additional qualification.
- Diabetes training was available for all nursing staff.

- Doctors told us that they had good clinical support and educational opportunities in the hospital. They also felt that there was "good teamwork".
- Nearly 90% of all staff working within the division of medicine and cancer had received an appraisal between April 2013 and March 2014, against a trust target of 88%.

## Multidisciplinary working

- Multi-disciplinary team working was seen as effective and resulted in good outcomes for patients. We saw examples of rehabilitation services working together to support safe discharge of patients and support for carers. Within the acute stroke unit there were daily multi-disciplinary team meetings to share information.
- We observed a multi-disciplinary team meeting discussing the discharge of a patient. There was effective communication, with clear goals and actions set. The patient's views and needs were represented by nursing staff. These were discussed and recorded in the medical notes before actions were agreed. Most patients told us that nursing and medical staff discussed their discharge arrangements with them. We observed staff discussing discharge arrangements with patients.
- An example of some of the work undertaken was that ward multi-disciplinary teams prioritised patient care daily. Instead of going to patients one at a time patients were prioritised in terms of medical need and those that were medically fit to go home. Patients could be discharged and receive important care and treatment quicker. This also enabled beds to be made available sooner for newly admitted patients. This met the recommendations made by the Royal College of Physicians report 'Future hospitals: caring for medical patients (2013).'

## Seven-day services

- There was a consultant medical rota seven days a week to ensure that there was seven day medical cover.
- All new patients would be seen by a consultant over the weekend and any patients whose condition could be cause for concern.
- There was a consultant ward round on the majority of wards seven days a week.
- Physiotherapy and occupational therapy provided a weekday service, in addition one service would work a Saturday and the other a Sunday to ensure therapy was

# Medical care (including older people's care)

available for patients each day. Physiotherapy in the trust provided an out of hours on call service for urgent patients, for example patients requiring urgent chest physiotherapy.

- Speech and language therapy was mostly available Monday to Friday.
- The cancer clinical nurse specialists and the diabetes specialist nurses provided a service from Monday to Friday, 9am to 5pm; there were no plans for seven-day working. There were guidelines for the out-of-hours management of minimally symptomatic adults with newly diagnosed type one diabetes on the intranet for staff to refer to when the diabetes specialist nurses were not in the trust.
- There was access to a pharmacy 24 hours a day seven days a week.

## Access to information

- On the care of the elderly and respiratory wards patients and those that care for them had access to a variety of information. This information was available on ward notice boards and on leaflet racks. There was self help information regarding foot care, dementia, caring for people who had suffered a stroke.
- Wards were inconsistent in how information was displayed. Some wards had very clear displays and leaflet racks. Other wards had empty racks or information placed in a corner where it was more difficult to see.

## Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- Staff told us they were aware of their responsibilities around the Mental Capacity Act and Deprivation of Liberty Safeguards. They were able to demonstrate a good understanding of the process.
- The mental health team attended the wards on request to support patients to make decisions if needed.
- We observed patients being asked for verbal consent prior to procedures being carried out.

## Are medical care services caring?

Good



that staff were friendly and that they felt they were being looked after. Patients felt that their dignity and privacy were respected and we observed this on the wards. We observed kind and compassionate care on all the wards we visited.

The Friends and Family Test was used and the results displayed on most wards. The trust response rate was worse than the England average however most medical wards had a response rate better than the England average. Scores were mixed but mostly better than the England average. Wards displayed the results on large notice boards on ward corridors and staff took pride in displaying their results.

## Compassionate care

- Most of the patients we spoke to were positive about staff and the care they received: "Staff couldn't have done more", and, "Caring", and, "These people do a good job", as well as, "Staff have really looked after me." Another patient commented that the porters were marvellous.
- Three patients we spoke to said they had experienced or witnessed a lack of caring and compassion by staff. One patient commented that the nurse was "Efficient, but cold" and described 'bad manners.' Another patient commented, "I feel rushed getting up. I'm made to get dressed and sit in the chair when I wanted to stay in bed".
- The trust used the NHS Friends and Family Test (FFT). This was a single question survey which asked patients whether they would recommend the NHS service they had received to friends and family who needed similar treatment or care. The average FFT response rate for the trust was 27%, which was worse than the England average of 30%. The average response rates for medical wards varied from 29% to 60% (from April 2013 to July 2014) with all but one ward were better than the England average. The response scores (scores out of 100) were consistently above the national average for most wards.
- The FFT response rates and scores were displayed on most wards on large notice boards alongside other ward performance scores. The trust used patient comment cards for collecting FFT responses. Staff told us they were proud of how well their wards were performing. Staff were also aware of the patient comment cards however they were not freely accessible to patients and not prominently displayed on most wards.

Overall patients we spoke with were positive about the care they received from staff. A number of patients commented

# Medical care (including older people's care)

- We observed good interactions and compassionate care on all the wards we visited. Staff spoke to patients in a caring manner asking questions such as 'how do you feel today?' Staff took personal interest in patients asking them about their home or social life.
- We saw that patient dignity and privacy were respected. Staff used curtains around beds and when helping patients out of bed ensured that they were covered up to preserve dignity. In the patient-led assessment of care environment (PLACE) survey the trust scores for dignity and privacy had been better than the England average for the last two years. The majority of patients felt that their dignity and privacy had been respected.
- We observed nutritional assistants supporting patients to eat and drink at meal times. Patients were allowed and encouraged to eat and drink at their own pace. Nursing staff we spoke to were very complimentary about the nutritional assistants as they allowed for better personal care and support for patients who needed it. It also allowed other staff to concentrate on other aspects of care for patients.

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

- We observed staff on all wards involving patients and their families in their treatment and care. Staff talked through discharge arrangements with the patient and their family and asking them if they were happy with the plan put in place.
- Staff talked through what was happening with the patient whilst administering care and treatment ensuring that the patient was aware of what was happening to them. A patient said, "As soon as I entered, explanations were given about care and treatment". A relative told us that the doctors, "Were updating me on his [the patient] care."
- The nursing and medical records had evidence of involving patients or their relatives; there were notes of discussion between patients and relatives, including preferences regarding their care and treatment. As a result of this there was evidence through the notes that care was patient focussed.
- Patients receiving rehabilitation following brain injury were involved in setting their own goals and targets with staff. This meant that patients were fully involved and at the centre of their rehabilitation. One of these patients had chosen to make their own meals, rather than have meals provided by the hospital.

## Emotional support

- The hospital had a faith centre which patients or their families could use for prayer and emotional support. Members of staff from the centre visited patients and families on wards. A patient told us they were offered a visit from the chaplain.
- Nursing staff told us that counselling services were available to patients and their families and were always offered following the death of a patient. The hospital does have a directory of bereavement services including counselling and social groups for adults and children. There are also quiet rooms available so families can have privacy.
- The Alzheimer's Society had a presence in the hospital. They provided listening and awareness sessions for staff, patients, relatives and carers. They provided specific sessions for carers once a week on Ward 406 and had a small meeting room on the ward. This allowed carers, patients and their relatives access to support and advice as well as having their views listened to.
- Staff and patients told us that visiting hours were flexible on some wards especially when some patients were at the end of their life or seriously ill. One relative told us "[it's] not a problem me being here whenever I want as [the patient] is so ill."

## Are medical care services responsive?

Good



The trust has several initiatives to discharge patients from hospital as soon as they are well enough or able to leave. This means that patients can rest and recover at home, or in a place they are comfortable sooner and have less time in hospital.

The trust worked together with partners and commissioners at a strategic level to respond to the needs of the population, patients and winter pressures. The trust worked with key charities to provide better response to patient needs. Different departments worked together to provide better environments for patients with complex needs.

# Medical care (including older people's care)

There were initiatives and facilities on wards to meet the need of individual patients. Patients were encouraged to identify goals and targets and their needs assessed so that the right level of care could be provided. We saw patient-focussed approaches to care and treatment.

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

- The hospital worked with charities such as the Alzheimer's Society and Changing Faces to plan and deliver services to meet the needs of patients.
- The trust was part of Derby's urgent care board (UCB), a partnership group made up of clinicians, the local authority, and other specialists. The UCB aimed to collectively solve or prevent key issues regarding patient care and flow. Action plans had been developed to address key problems in these areas and to improve services for patients.
- Plans to meet winter pressures included allocating an extra 48 beds, providing a service to provide cover seven days per week, and to ensure additional staff were in place.

## Access and flow

- Bed occupancy rates for general and acute medicine were 87% between April and June 2014 and 86% between July and September 2014. This was worse than the England average. It is generally accepted that, when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the hospital. Many of the wards we visited were full and did not have any available beds.
- Data from the trust showed that the majority of patients (92% between April and August 2014) did not have any bed moves during their inpatient stay. No patient moved more than twice upon admission to hospital. Most patients we spoke with had experienced minimal bed moves.
- There were bed management meetings held during the day and when required in the evening to discuss available beds, medical outliers, the movement of patients and to discuss those patients that could be discharged from hospital. We observed one bed meeting and saw that there was comprehensive discussion regarding the management of admissions and discharges. There was effective communication between staff attending this meeting.

- Each ward had a dedicated discharge coordinator who was a member of the nursing staff. The discharge coordinator would take responsibility for ensuring everything was in place for a patient to be able to leave the hospital. This allowed for a single coordinated approach and contact for patients and their families. It also allowed nursing staff to focus on the care and treatment of patients. Some staff raised concerns that the role left numbers of nursing staff short and that there was a lack of cover if the designated discharge coordinator went off sick.
- Patient discharge dates were discussed at daily multidisciplinary team meetings. This was to ensure that those patients who were medically fit could be prioritised to leave the hospital.
- On the stroke ward there was an early supported discharge programme, which enabled patients who were medically fit to recover at home. The multidisciplinary team planned support and care for the patient at home so that the patient could leave hospital early. This was facilitated by the community-based Stroke Support Team.
- The hospital also had a team of discharge support officers, who worked separately to discharge coordinators. The majority of nursing staff found that the discharge support officers were helpful. Their role was to liaise with the patient, their family, and any other agencies involved, ensuring that the patient had everything they needed to leave hospital. A ward sister commented that: "They do all the chasing for you," which allowed nursing staff to concentrate on caring for patients.
- There was a transfer and discharge team working at the Royal Derby and London Road Community Hospitals. The team worked with wards to identify patients who could be treated more appropriately in the community, rather than in hospital. The team ensured that ongoing care was in place and tracked the patient until they were ready to go home. This provided positive psychological and physical benefits to the patients, such as a reduced risk of infection while they were in hospital, allowing for recovery in a location they were familiar with. This also enabled beds to be made available earlier for patients who were being admitted.
- Prior to discharge, patients' needs were assessed so that the correct level of care could be put in place at home or a care setting. On the stroke ward we saw staff working with a patient to undertake a kitchen assessment. This

# Medical care (including older people's care)

was to assess the patient's ability to undertake tasks in the kitchen before going home. As a result of such assessments the hospital would then make appropriate discharge arrangements with care agencies or families. We also saw a bathroom where similar assessments were made by staff. There was a gym on the stroke ward where patients worked with staff on physical rehabilitation and assessments.

- There was a patient discharge lounge in the hospital operating from 8am to 8pm, Monday to Friday. If a patient was medically and clinically discharged from a ward they could transfer to the discharge lounge while awaiting final arrangements to be made. For example, to arrange transport or medication to take home. This enabled beds to be made available earlier for admissions. The discharge lounge was staffed with both qualified nurses and healthcare assistants, who could continue the care of the patient.
- The discharge lounge provided three patient beds and chairs for up to 17 patients. The unit had one toilet, which did not adequately meet the needs of patients.
- Medical and nursing staff told us that most delays in discharges were because patients were waiting for care packages to be put in place if returning to their own home, or for a rehabilitation or care home places to be made available.
- Staff told us they felt that there was good communication and work between hospital staff and social care providers. We saw evidence in medical notes of working with local authorities, care homes, and GPs in discharge planning. Statistics for the trust showed that delays in transfer of care, such as patients waiting for care to be arranged at home or for a care home placement, were better than the England average.
- Patients who were leaving hospital told us delays on the day of discharge were mainly due to waiting for medication. Most patients we spoke to had said that they had been informed and involved in their discharge arrangements. One patient told us that "there has been good open communication and flexibility", regarding their discharge. A small number of patients told us that they had to wait until late in the day to be discharged.
- The trust was meeting its operational standard across all medical departments for referral to treatment times. This meant that the majority of patients were waiting a maximum of 18 weeks between being referred and being seen for treatment.

- At the time of our visit there were five medical outliers across the hospital. Outliers are patients under the care of medical consultants but placed on other wards due to a shortage of bed space. Outliers were discussed at the bed meetings each day so that the patients can be moved onto medical wards wherever possible.
- Where patients were not situated on the appropriate ward the hospital has allocated teams and consultants to monitor and care for the patient. Wards have teams and allocated consultants linking them together so that patients could still receive the care and treatment they would get on the appropriate ward.

## Meeting people's individual needs

- There was an interpretation service available for patients and their families who did not have English as their first language. Staff told us they had used this service especially when a doctor needed to have a clinical conversation with the patient. For more informal discussions family members were often used to communicate with the patient. We observed an interpreter being used with one patient and their family to assess the patient who had been admitted for treatment following a stroke.
- Patients over the age of 65 were routinely screened for signs of dementia. This enabled staff to put in place the right level of care and escalate any issues. If there were signs of dementia it would be escalated to medical staff to undertake further assessment. We saw examples of completed screening questionnaires and escalation in patients' records. We saw patients living with dementia receive one-to-one support and that they were responded to quickly.
- The trust had a dementia liaison team who collect information about a patient's family, social background and history. This was to gain a better understanding of the patient and to ensure the level of care can meet the needs of the individual patient. This information was available to staff in the patient's records.
- The hospital lead for dementia told us there was no standard method of documenting the needs of patients who were living with dementia. The trust was trialling new documentation for understanding the needs of patients living with dementia on two wards and it was hoped that this would be rolled out to all wards.
- The hospital had a dementia steering group which focussed on improving care for patients living with dementia. The dementia steering group involved staff



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from other specialities and organisations, such as the local authority. The steering group had developed a dementia care framework based on national guidance, including the National Institute for Health and Care Excellence (NICE) clinical guidelines.

- In MAU between 10am and 6pm a health care assistant with qualifications in caring for patients who were living with dementia was available to assist patients in the FEAT lounge. We saw this role as effective in supporting people living with dementia.
- We saw a wide range of information available to patients and their families on large notice boards and leaflet racks on the wards. The notice boards were clearly visible and accessible for patient and families. The leaflet racks on some wards were untidy and less prominently displayed. All the information we saw was written in English and so was not easily accessible for some patients who did not have English as their first language.
- Patients living with dementia, learning disabilities and mental health problems were provided with one to one support where needed on wards. Senior nursing staff described how the staffing on some wards was flexible to ensure that patients had the support they needed. There was an increased supervision policy that senior nursing staff could use to increase staffing levels to meet patients' needs. This may be to provide assistance with tasks or activities or to ensure patients' safety. Some wards operated supervised bays where patients who needed it could have continual support and supervision. .
- On ward 301 we observed that patients and their families had access to a day room. In the day room patients could eat their meals, relax with family members, watch films and take part in group activities. The patient white board on the ward also had just the patients' first names written to try and help patients feel relaxed and to try and create an informal atmosphere. This ward provided rehabilitation for patients with an acquired brain injury. Patients often spent long periods of time on the ward so it was important for them to feel relaxed and comfortable.
- The wards providing care for older people, wards 401, 405, and 406, had 'reminiscence rooms' for patients and their families to use. In the rooms there were old photographs, a television, an old radio and games. We found that the reminiscence rooms were not used whilst we were visiting. One member of nursing staff said that

the room on their ward was, "Rarely used." A member of nursing staff on a different ward said that their room was used once a week. This was due to some patients choosing not to go in there, patient mobility, and staffing, especially when there were a number of patients requiring a higher level of care.

- Many of the medical wards provided activities for patients, carers, and their relatives. We were informed by patients and staff of films being shown, day rooms being used, and patients were able to have communal lunches and meals. We observed musicians on one ward entertaining patients and encouraging them to sing along.
- The hospital had utilised arts council funding to set up the 'Banishers of Boredom' (BOB). This was a small team of staff who interacted with patients and provided suitable activities. One example was a board game that allowed patients of different abilities to have varying levels of participation, ensuring no-one felt left out.
- Three patients told us that they had to wait for nursing staff to provide care and treatment. One patient told us they had been waiting two hours for pain medication. Another patient described having to wait 20 minutes before being assisted to the toilet. Two other patients told us that they felt they had to wait longer at night to receive treatment and care.
- We saw that patients' individual needs were assessed and noted in their records. Staff demonstrated a focus on providing care and support that met patients' individual needs.
- The trust has a section of its website dedicated to people with learning disabilities. The section provided videos on what to do and where to go for different services that the hospital provides. The videos had subtitles so people with hearing difficulties could access the information. The learning disabilities section of the website also provided booklets for patients and staff on treating and assessing people with learning disabilities.

## Learning from complaints and concerns

- Information available to patients and visitors about how to raise concerns or complaints was available. We saw no information displayed about how to raise safeguarding concerns.
- Nursing staff told us they knew how to deal with concerns and complaints. Most staff we spoke to

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wanted to try and deal with concerns quickly and immediately. If this could not be resolved, patients would be signposted to the Patient Advice and Liaison Service.

- One patient we spoke to had raised a concern about the attitude of a member of staff and this had been dealt with quickly by the nurse in charge. An apology had been given to the patient.
- Nursing staff told us that they received positive feedback and learning from complaints. Feedback from patients was shared in a variety of ways, including staff noticeboards, emails, team/ward meetings and newsletters on the back of staff toilet doors. Ward managers had tried different ways to share the information to ensure that it was seen by all staff. There was a lack of consistency in how information and feedback was shared with staff.

## Are medical care services well-led?

Good



The trust's vision statement was prominently displayed in all areas of the hospitals. Staff working in medicine and elderly care were aware of the trust's vision and demonstrated commitment to its objectives and values.

There were suitable arrangements to identify and manage risks, and to monitor the quality of the service provided.

Staff felt well supported by their immediate managers and were positive that their achievements were recognised. They felt encouraged to bring ideas for improvements to services. Staff were proud of the standard of care they provided and of that their achievements were recognised.

### Vision and strategy for this service

- The hospitals vision was "Taking pride in caring". Staff were aware and understood the vision and values of the trust and how their role and behaviours would help to achieve these values.
- Ward managers told us that they discussed the trusts values during ward meeting, handovers, recruitment interviews and during staff appraisals.
- The trust had a clear vision statement displayed prominently in all areas of the hospitals and on the hospitals website.

### Governance, risk management and quality measurement

- Monthly ward to board quality reviews were completed and monitored. These included monitoring comfort round checks, speaking with the patients, ward cleanliness and patient knowledge and understanding of their medication.
- There were monthly risk meetings within the medical and cancer division. During these meetings, risks and actions were identified to reduce risk. One item on the division risk register was the waiting list for endoscopy and the need to have Saturday lists. Staff in endoscopy confirmed that the Saturday lists were in place. Staff were able to show us progress made up until the time of the inspection to address the waiting list.
- Risks that affected the delivery of safe care were clearly identified on the division's risk register. Staff told us that they could add risks to the risk register at any time. The risks were then assessed by the patient safety lead and categorised into division, or trust risks. The risk logs included actions that were required to reduce risk and were reviewed at each risk meeting. This showed that risks were appropriately managed.
- A root cause analysis investigation was undertaken following each serious incident. The investigations undertaken were detailed identified actions to reduce the risk of further similar incidents in the future.

### Leadership of service

- Ward level leadership was found to be robust and effective. However when we visited unannounced we found a nurse in charge of one ward who had been qualified for one year with other newly qualified nurses staff on duty who required supervision. The nurse in charge told us about difficulties they had experienced and despite asking for assistance no support was made available. We identified our concerns and possible risks to other patients and staff to the senior nurse on duty for the hospital.
- "The Pride of Derby" awards identified the outstanding achievements of individuals or teams and certificates of these awards were proudly displayed on the wards and units we visited. Nursing staff also told us how much they valued this initiative.
- Ward sisters told us that they had weekly meetings with the divisional nurse to discuss patient safety risks.

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- Nurses told us that matrons were visible and supportive and felt able to raise concerns. They also felt they were listened to.

## Culture within the service

- Staff told us that the hospital was a friendly place in which to work and they liked coming to work. Staff in several areas we visited commented that they were “a good team” They told us that they would bring their friends and family to the trust for care.
- Staff commented that patients come first.
- Staff were encouraged to complete incident forms or raise concerns. Staff felt that these concerns were usually adequately addressed and were appropriately responded to by senior managers.

## Public and staff engagement

- The role of the volunteer was a vital role within the hospital working in a variety of departments alongside staff. Patient representatives were visible throughout the hospital.
- There were weekly ‘Back to the Floor’ walkabouts undertaken by nursing leads, matrons and senior nurses. In addition, the chief nurse and medical director carried out back to the floor walkabouts at least every month. Most nurses we spoke with were aware that visits had been undertaken. One newly appointed ward manager said the ward had received more than one ‘walkabout’ and felt that senior managers were approachable and supportive.
- Patient comment cards were only available in English and not in other languages. Information about patient feedback was displayed, but not prominently. The information was also in English only, meaning that patients whose English was not their first language would not be able to understand the information or feedback using comment cards.

- A member of the nursing staff told us that they could not use the comment cards on their ward because of the design. The comment cards “were not suitable for patients with cognitive and memory impairment”, meaning that patients were not able to read and feedback to the trust. Another member of the nursing staff told us that they were involving families and carers in helping patients fill out the comment cards so more patients could feedback.

## Innovation, improvement and sustainability

- Staff told us they had opportunities to raise issues or bring ideas for improvement and they felt listened to. A consultant said, “Managers are responsive to our ideas and any need for changes are always discussed first.” Another consultant told us that the “executive listened” when bringing proposals and ideas forward.
- There were appropriate systems in place to review service delivery and, when needed, ensure that lessons were learnt and appropriate actions taken.
- Respiratory medicine had been awarded a team award in October 2014 in the East Midlands Innovation in Healthcare awards. Colour-coded wristbands had been introduced to simply identify how much oxygen each patient needed. Excessive amounts of oxygen could be dangerous for some patients and it is important that the correct amount is administered.
- The medicine and cancer division had a cost improvement programme. Some were concerned because of staffing and felt they couldn’t stretch their budget any further and were relying on their trust funds. But other staff said they had no problem getting extra staff or equipment.



# Surgery

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

## Information about the service

The surgical division provided 337 inpatient beds across 13 ward areas and included; general surgery, ophthalmology, ear, nose and throat, vascular, upper and lower gastrointestinal (GI), urology, bariatric surgery, orthopaedics, theatres and anaesthetics, and outpatients. Services for surgical patients were provided in outpatient's consultation sessions, the pre-operative assessment unit, day surgery and inpatient wards including the surgical assessment unit. There were designated anaesthetic and operating theatres for the surgical directorate, with an associated recovery unit.

We visited the elective admissions lounge, general surgery day surgery unit, operating theatres and recovery, nine surgical wards and the surgical assessment unit.

During our inspection we spoke with 37 patients and two visiting relatives. We spoke with 31 staff from a range of various related surgical roles and held group discussions with trainee doctors and senior managers during our visit.

Over the three days of our inspection we reviewed treatment and care records for 18 patients and made observations of staff interactions with patients during the course of their activities. We also reviewed the arrangements in place to support the delivery of elective and emergency surgery, including the environment and provision of resources.

## Summary of findings

The surgical division had systems and processes in place to keep patients safe. Staff had a good awareness of the process for identifying and recording patient safety incidents.

Arrangements to minimise risks to patients were in place with measures to prevent falls and pressure ulcers, the early identification of patient risk during surgery, good infection prevention and control practice and, the safe management of medicines.

Staff were competent and suitably trained to deliver care in line with the Trust policies and procedures, national guidance and, NICE quality standards.

Access to care and treatment and surgical outcomes for patients were mostly within the national average. Where improvements were required these had been identified and measures were in place.

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## Are surgery services safe?

Good



Overall we found surgical services at this trust were safe.

Whilst a never event had taken place in addition to a number of serious incidents, we found the process of investigations to be robust. We saw where actions had been identified and implemented as a result. All staff had a good awareness of the process for identifying and recording patient safety incidents including near misses.

Arrangements to minimise risks to patients were in place with measures to prevent falls and pressure ulcers and, the early identification of patient risk during surgery. We saw elements of good practice including the use of safety dashboards; clean clinical areas and good infection prevention and control practice. However, we saw where venous thromboembolism (VTE) assessments were not always completed appropriately.

There were vacancies within the surgical division however; these were managed effectively at a local level to ensure there was no disruption to care delivery. We saw there was good access to senior clinicians when required.

Medicines were mostly stored safely and we observed good practice where staff followed a safe medicines administration procedure.

Mandatory training compliance was within the trust target.

Patients' individual care records were accurate, complete, legible and up to date. However, we saw where records and patient identifiable information was not always stored securely.

### Incidents

- One never event was reported as occurring within the surgical division between November 2013 and November 2014. Never events are classified as such because they are so serious that they should never happen. The never event related to the administration of insulin. The ward manager told us they had completed a root cause investigation of the incident

and actions from the investigation included 'think glucose' training for the staff involved and a revision of the electronic prescribing and medicines administration (EPMA) system.

- In addition to this a further five incidents relating to different aspects of diabetic care and insulin administration had occurred in the surgical division in the six weeks preceding our inspection. Senior managers told us a root cause analysis of all the incidents had been carried out and we saw where actions had been taken as a result.
- For the period April 2013 to March 2014 we saw where there were a total of 43 serious incidents requiring investigation within the surgical division, of which half related to Grade 3 pressure ulcers. We discussed this with senior managers who told us a review was undertaken on the trauma and orthopaedic wards. The review had resulted in a general decrease in grade 3 and 4 pressure ulcers in recent months with four reported between June and November 2014.
- Incidents and near misses, where patient safety may have been compromised were reported via the trust's online incident reporting system. All the staff we spoke with on the wards and in theatres were aware of the incident reporting system and gave examples of the circumstances in which they would raise incidents. We saw, via email and on staff noticeboards in both theatres and the wards, instances in which incidents had been communicated and at these times, learning was shared.
- Within the surgical division local specialties participated in morbidity and mortality (M&M) meetings. Minutes we received following our inspection demonstrated these meetings provided opportunities to review all unexpected deaths and identify trends.

### Safety Thermometer

- All the wards we inspected had a safety dashboard on display, this meant patients and the public could see how the ward was performing in relation to patient safety.
- We reviewed the Safety Thermometer dashboards on five wards for the period of June to November 2014. We found the main area of safety related to catheter-related urinary tract infections (CUTIs). For example, on ward

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310 there was one CUTI in June, September and October, four in July and three in November. The average percentage of 'harm free' care across the five wards for the same period was consistent, at 97%.

- During our inspection we saw where venous thromboembolism (VTE) assessments were mostly completed. The VTE assessment was completed by the doctor prior to prescribing interventions such as anti-embolic stockings and prophylaxis treatment for the prevention of blood clots. We reviewed data on five wards for the period June to November 2014. We found the main area of safety where VTE's were not always completed was the surgical assessment unit where we saw an average of 74% completed VTE assessments over a six month period. VTE assessments in the other four areas were in excess of 90% over the same six month period.

## Cleanliness, infection control and hygiene

- All the wards and theatres we visited were clean and well maintained. There were procedures for the management, storage and disposal of clinical waste, environmental cleanliness and prevention of healthcare acquired infection guidance.
- Infection control link nurses were available on the wards we visited. Staff told they us were responsible for completing monthly infection control audits. All the wards we visited had achieved audit results of greater than 90%. Staff told us audit results would be reported on and issues identified would be fed back to ward staff at handover, through email, on staff notice boards or at ward meetings. On all the wards we saw audit results displayed in the clinical area.
- On all the wards, and in theatres, we observed staff to be complying with best practice with regard to infection prevention and control policies. Staff were observed to wash or use hand sanitising gel on their hands between patients. There was access to hand washing facilities and a supply of personal protective equipment, which included gloves and aprons. All staff were observed to be adhering to the dress code, which was to be 'bare below elbows'. Staff in the theatres followed correct technical procedures for scrubbing up prior to commencing surgery.
- Within the surgical division, there were no cases of MRSA and nine cases of C. difficile reported in the 12 months

prior to our inspection. A root cause analysis of all C. difficile cases had been undertaken. We saw that these were discussed at the C. difficile root cause analysis meeting and learning points had been identified.

- Across the surgical wards we saw where patients were nursed in isolation to prevent the spread of a health care associated infection. There were notices on the doors of the patient's room outlining the infection control precautions required in order to prevent cross infection. Staff were mostly observed adhering to these precautions throughout our inspection.
- Staff within the surgical division were observed to be following the National Institute for Health and Care Excellence (NICE) guidelines CG74 for 'Surgical site infection: prevention and treatment of surgical site infection' (2008). Staff on the wards were not aware of whether or not surgical site infections were monitored and were unable to recall a recent surgical site infection.
- Staff reported that following aseptic non-touch techniques (ANTT) when changing wound dressings. For the period of April 2013 to March 2014 eight out of 62 patients (12.9%) were either an inpatient or readmitted with a surgical site infection. This was worse than the national average for the same period which was 8.4%.
- There were processes in place for the cleaning and decontamination of instruments used in theatres. The trust had an on-site hospital sterilisation and disinfection unit (HSDU). Staff told us there were very few issues with the cleaning and decontamination of instruments and the process was completed in a timely manner.

## Environment and equipment

- Theatres were based in two areas of the trust with main theatres accommodating general surgery, emergency, trauma and orthopaedics and, the Kings Treatment centre accommodating general surgery, ophthalmology, urology and hands day cases. We observed the anaesthetic rooms, clean and dirty utility areas and recovery areas in both departments.
- We observed all patient-care equipment to be clean and ready for use. Patient equipment had been routinely checked for safety with visible portable appliance testing (PAT) stickers demonstrating when the equipment was next due for service. In day case theatres staff had not previously documented their daily check of anaesthetic equipment. Prior to our inspection an

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incident involving an anaesthetic machine malfunction prompted staff to document their daily checks. During our inspection we saw where staff had signed to say where equipment had been checked.

- The resuscitation equipment on the wards and in theatres was clean. Single-use items were sealed and in date, and emergency equipment had been serviced. We saw evidence that the equipment had been checked daily by staff and was safe and ready for use in an emergency.

## Medicines

- The hospital used an electronic prescribing and medication administration (EPMA) system for patients which facilitated the safe administration of medicines. Staff told us this system reduced the likelihood of medication incidents and gave us examples of where prompts in the system would prevent staff from giving a drug at the wrong time or would prompt for a recorded reason for the omission of a drug. Ward managers told us about incidents that had occurred in which the EPMA system enabled them to access clear information in order to assist them in incident investigations. For example, there was a clear record of which member of staff had administered the medication.
- We looked at the prescription and medicine administration records for 28 patients across six wards. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed patients were getting their medicines when they needed them. If patients were allergic to any medicines this was recorded on their electronic prescribing and medication administration record. Where medicines had not been given reasons for omission had been documented.
- Medicines were mostly stored safely on all the ward areas. We looked at the clinic rooms on the wards and anaesthetic rooms in theatres where medicines were stored and found that the medicines fridge temperature was mostly being monitored and recorded regularly.
- However, on ward 308 fridge temperatures were not always being monitored according to trust policy. On 20 occasions in November, 18 occasions in October and 9 occasions in September we could see no record to confirm that the temperature had been checked. Nursing staff were unable to give us a reason for this.
- We reviewed the storage and administration of controlled drugs on the wards and in theatres. We found them to be stored appropriately and drug records were accurately completed. Emergency medicines were available for use and there was evidence that these were regularly checked.
- We observed good practice where staff followed a safe medicines administration procedure. During medicine administration rounds staff were observed to be wearing a red 'do not disturb' tabard. Staff told us this helped to reduce the number of interruptions, and potential medication errors, to the nurse during the medicine round.
- Medicine errors were reported as part of the trust incident reporting process. Between June and November 2014 there were 84 out of 758 reported incidents that related to medicines. 17 areas within the surgical division had reported incidents related to medicines with wards 307, 308 and 311 reporting the highest numbers. Reasons for raising incidents were largely due to a delay or failure to monitor or follow-up following administration of a drug or medicine and, omission or delay in administration.
- Staff told us they had good access to pharmacy advice and support. A pharmacist visited all wards each weekday. We saw that pharmacy staff checked that the medicines patients were taking when they were admitted were correct and that records were up to date. Medicines interventions by a pharmacist were recorded on the system to help guide staff in the safe administration of medicines.
- There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. This meant that patients had access to medicines when they needed them.
- An antimicrobial policy and prescribing guidance was available to medical and nursing staff in both written and electronic format via the trust intranet. This provided staff with guidance in order to avoid inappropriate antibiotic prescribing.

## Records

- All the staff we spoke with were aware of their responsibilities around the safe keeping of records and confidentiality of patient information. Throughout the

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wards and theatres we saw where patient identifiable information was mostly stored securely. However on three of the wards we saw where patient information was not stored securely.

- On the surgical assessment unit, notes trolleys were stored in the clinical area. These were not covered and did not restrict access to unauthorised persons. We also found a set of medical notes at an unattended nurses' station, in public view. On ward 309 we observed three unattended computer screens where individuals remained logged in. This meant that there was a risk of access by an unauthorised user. On one screen, a patient's diagnostic imaging results were clearly displayed. On ward 308 and 309, we saw unattended notes trolleys that were not secure. Within the trolleys loose sheets of patient information were not filed securely within the patient notes.
- Breach of confidentiality and/or data loss incidents were reported as part of the trust incident reporting process. Between June and November 2014, nine such incidents had been raised across the surgical division. Three incidents related to patients' personal information being located in an unauthorised area and two related to a patient attending for treatment with incorrect patient information within their medical notes.
- We observed nursing and medical notes as part of our inspection. We noted that nursing records were well organised and information was easy to access. Records were mostly complete and up to date. We saw minimal gaps in the nursing documentation. Where gaps were observed they related to the absence of a date or signature. Each patient had a completed admission assessment booklet, which included biographical details and contact details for next of kin.
- Records showed where staff had completed a standardised risk assessment booklet. This included risk assessments for moving and handling, pressure ulcers, falls, bed safety and malnutrition. All the risk assessments completed followed a nationally recognised practice tool
- We saw where additional information stored within the nursing notes related to the care of the individual patients. Examples included a pre-procedure checklist and enhanced recovery pathways relating to a specific procedure.

- Medical notes contained well documented information on admission and following daily reviews and we saw evidence of multi-disciplinary input from allied healthcare professionals and specialist nurses.

## Safeguarding

- Most staff had an understanding of how to protect patients from abuse. We spoke with staff who could describe what safeguarding was and the process to refer concerns. Staff gave us examples of where they had raised safeguarding concerns as a result of bruising noted on a patient, and another of suspected financial abuse.
- There was a safeguarding procedure on display in all of the wards and in theatres. Further information and guidance was also available through the trust intranet.
- Information received prior to our inspection showed the overall uptake of safeguarding training across the surgical division to be 91% against a trust target of 80%. Most staff we spoke with across the multi-disciplinary team told us they had received some form of safeguarding training since commencing employment at the trust.

## Mandatory training

- The trust had a policy for mandatory training. Nursing, medical and therapy staff we spoke with across the surgical division reported having good access to mandatory training and described 'one-stop shops' where they could turn up for training without being booked and that there was a trust online library of e-learning modules they could access. We were told this resource covered the majority of the mandatory training subjects.
- Information received from the trust before our inspection showed the overall completion rate to be 86% where staff across the surgical division were up to date with mandatory training appropriate to their role. We saw that individual areas maintained a mandatory training matrix at local level. For example, in day case theatre and on the surgical assessment unit, mandatory training compliance overall was at 90%.
- Staff had online mandatory training passports. These could be accessed at work or home and allowed staff to keep a record of where they had attended training, or when an update was required. Senior managers were able to access staff training passports in order to gain an overview of training requirements across the service.



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- We received mixed feedback from therapy staff regarding mandatory training. While most permanent staff told us that they had good access to training, locum staff reported not having completed key mandatory subjects and that they had no access to online training.

## Assessing and responding to patient risk

- In theatres, staff followed the 'five steps to safer surgery' procedures (Patient Safety First campaign – an adaptation of some of the steps in the WHO surgical safety checklist), which included: a team brief before commencing operating lists, sign in of the patient before anaesthesia, the 'stop' moment before surgery commenced, sign out before staff had left the theatre and a debrief following each list.
- Staff in theatres used a document based on the World Health Organisation (WHO) safety procedures: 'WHO surgical safety checklist – No Stop No Op!' to ensure each stage of the patient's journey was managed safely. Audit results for March 2013 indicated 100% compliance with the 'Stop' moment and 98% compliance with identifying the procedure and site before surgery commenced.
- Emergency theatre provision was available 24 hours a day, seven days a week with a further theatre available during afternoons and evenings. Patients requiring an emergency operation were referred to the on-call anaesthetist and theatre co-ordinator by the medical staff responsible for their care.
- Surgeons used the physiological and operative severity score for the enumeration of mortality and morbidity (POSSUM) to calculate patient risk in terms of morbidity and mortality prior to surgery. The POSSUM score was often recalculated following surgery by the anaesthetist. We were told this was because the morbidity and mortality risk could increase depending on the level of surgery that had taken place.
- In accordance with the trust's resuscitation policy, staff used an early warning system to record routine physiological observations, such as blood pressure, temperature and heart rate. This was used as part of a 'track-and-trigger' system whereby an increasing score triggered an escalated response. The response varied from increasing the frequency of the patient observations up to urgent review by a senior nurse or the doctor.

- In the nursing records we reviewed we saw where staff were following National Institute for Health and Care Excellence (NICE) guidance CG50: "Acutely ill patients in hospital: Recognition of, and response to, acute illness in adults in hospital." Observation records were complete and we saw where escalation had taken place appropriately. On one ward, we saw staff use the Situation, Background, Assessment, Recommendation (SBAR) communication tool. This enabled staff to communicate critical information that required immediate attention and action in a structured way.

## Nursing staffing

- Throughout the wards and theatres, we saw sufficient staff, of an appropriate skills mix, to enable the effective delivery of care and treatment. In all areas including theatres we saw where there was a band 6 nurse, or above, on duty to support the nursing team.
- Most nursing staff reported having enough staff on duty to deliver care. However, during our unannounced visit we were told the level of acuity and dependency of the patients was high and while the ward was correctly staffed, staff felt under pressure due to their workloads.
- There were a number of registered nursing vacancies across the surgical division, with the surgical assessment unit, elective admissions and orthopaedic theatres having the highest vacancy rates. We did not see any negative impact on patient care delivery within these areas.
- We looked at staff rotas and saw that, where reduced staffing had been identified, there were plans in place to address the risk to care delivery. Ward and theatre managers told us staffing was looked at on a daily basis to enable the under filling of shifts to be addressed at the earliest opportunity. We were told that bank staff, obtained through the trust bank, were used on an ad hoc basis and requests did not need to be authorised at matron level.
- Requests for external agency staff did need to be authorised by the matron, but managers could not recall a time when their request had been denied.
- We found that each ward area identified the staffing levels for each part of the day and the number of qualified and healthcare support staff were displayed for public viewing.
- On the day of our inspection, the surgical assessment unit's actual number of staff for the early and late shift



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met the ward's requirements. We noted that the night shift had one less registered nurse than was required, this had been addressed and an additional healthcare support worker had been booked for the shift.

- At the time of our inspection, nursing staff on the wards were completing an acuity and dependency tool in order to measure the patient acuity and/or dependency. Staff told us this was completed periodically and fed back to matrons.
- On some of the wards within surgery, we saw where band 4 assistant practitioners (AP) were in post as part of the ward establishments. Staff reported this role as having a positive effect on the registered nurses workload on a day-to-day basis. We were told APs would cannulate patients, obtain and record physiological observations and, in some areas, collect patients from theatre recovery. One staff nurse told us, "They do everything except give out medicines."
- During our unannounced visit, we observed a nurse handover. Handover consisted of an audio tape prepared for the oncoming staff by the staff currently on duty. The handover of confidential information, including do not attempt cardio-pulmonary resuscitation (DNA CPR) details and relevant safety details took place in a private room away from the clinical area. Following handover, we observed the oncoming shift clarifying any issues, or information of concern before they commenced their shift.

## Surgical staffing

- Consultants within the surgical division provided 24 hour cover, seven days a week. On the surgical assessment unit, an additional consultant post to provide ambulatory care was currently vacant. At the junior doctor focus group, staff reported having good support from consultants. Doctors told us they had "no problems contacting consultants on call", and that "consultants tell us when they're going to be in theatre, but we can still contact them there. They'll answer phone calls or get us to come into theatre to talk to them". They also said that "the consultants here are very approachable – better than other places I've worked". Also, "if something goes wrong you get help very quickly".
- Ward staff reported twice daily ward rounds by the consultant or specialist registrar. However, for those wards with outliers not within their specialty, staff reported ward rounds that sometimes occurred later in

the day especially at weekends. They told us this was because medical teams would review their own wards before seeing outliers. Surgical wards were paired with a medical ward. This meant, if a medical outlier required a medical review, nursing staff were able to contact the 'paired' ward to access a doctor.

- On one of the orthopaedic wards we were told of daily ward rounds by an ortho-geriatrician who cared for patients alongside the orthopaedic surgeons and with the support of a specialist multidisciplinary team.
- There was vascular consultant cover 24 hours a day, seven days a week. However, doctors within the vascular surgical team felt there was a gap in support between 5pm and 8pm, as there was no consultant or registrar. They told us that they relied on nurses or the critical care outreach team at these times.
- On the surgical assessment unit, medical staff told us, "Our workloads can be very busy with patients coming in quicker than you can see them. Handover from A&E is not always as good as [it] should be. We sometimes get very little information and this causes delays in treating the patient."
- Most junior doctors we spoke with told us weekends were stretched although every patient was still seen every day. Most said they regularly worked late to get jobs and paperwork done.
- In theatres we were told a weekly sessional planning meeting occurred. As well as looking at theatre lists for the following week, medical and nursing staffing levels were also reviewed.
- Out of hours anaesthetic consultant cover in theatres was provided by two consultants and two specialist registrars. A foundation year 2 doctor was also available and based on the step down unit within the surgical division. We were told there was currently six vacant consultant posts within anaesthetics and recruitment was underway. Sickness and absence within anaesthetics was generally covered by internal locum doctors. If external locum support was required they would be required to attend a local induction programme.
- If locum support was required for unscheduled surgical care we were told the locum would be swapped with a member of the medical team on one of the general surgical wards.
- Within the recovery ward of the general surgery day case theatre, nursing staff reported challenges after 8pm

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regarding the medical review of patients. This posed a particular challenge where the patient may be deteriorating. We saw that this had been raised as an incident on the trust's online incident reporting system.

- We discussed this with the service leads for the surgical division. They told us that they were aware of the challenges and encouraged staff to escalate their concerns immediately through the trust resuscitation team. This allowed for immediate attention to the deteriorating patient by suitable qualified medical and nursing staff.

## Therapy staffing

- Throughout the wards, we saw sufficient therapy staff, of an appropriate skills mix, to enable the safe and effective delivery of care and treatment. Most therapy staff reported having enough staff on duty to deliver care. Therapy staff told us that, while their day-to-day work was busy, they did have manageable caseloads. Therapy staffing was supported through the use of locum or bank therapists.
- Handover between therapists and the nursing staff took place on the wards daily at 8.30am following the medical ward round. Therapy staff told us that at this handover meeting they would prioritise their caseloads to meet patient needs.

## Major incident awareness and training

- Most of the staff we spoke with were aware of the trust's major incident plan and business continuity plans, in place to ensure minimal disruption to essential services.
- The trust had a robust urgent care escalation and de-escalation plan that had been developed with representatives from nearby organisations and services including commissioning groups, neighbouring trusts, ambulance services and, social care and independent health organisations.

## Are surgery services effective?

Good



Surgical services at this trust were effective. Evidence based assessment, care and treatment was delivered in line with national guidance and NICE quality standards.

Pain management was effective. Patients received pain relief suitable to them in a timely manner and clinical staff were supported by a dedicated acute pain team.

Surgical outcomes for patients were monitored and were mostly within the national average. Where outcomes were worse than the national average these had been identified and measures were in place to make improvements.

A multi-disciplinary team approach was evident across all of the surgical division. We observed good multi-disciplinary working in all the wards and departments we inspected and saw where there was a shared responsibility for care and treatment throughout the teams.

Access to surgical services was available seven days a week providing on going 24-hour care for elective and emergency surgical patients.

## Evidence-based care and treatment

- Within the surgical division, patient needs were assessed and care and treatment was delivered in line with NICE quality standards. For example, clinical staff followed guidance relating to falls assessment and prevention, pressure ulcers, nutrition support, venous thromboembolism and recognising and responding to acute illness. In theatres, NICE guidance was followed in relation to oesophageal doppler monitoring, surgical site infections and the management of hip fractures in adults.
- The delivery of unscheduled surgical care was consistent with the Royal College of Surgeons standards on emergency surgical service provision for adult patients. This included 24-hour consultant availability and the use of a risk prediction tool in calculating morbidity and mortality risks during surgery.
- Anaesthetic provision followed the Association of Anaesthetists of Great Britain and Ireland and, the Royal College of Anaesthetists guidance. We were told that the trust had applied for Anaesthesia Clinical Services Accreditation (ACSA) in recognition of the high quality anaesthetic care that was delivered. ACSA is a voluntary scheme for the NHS and independent sector organisations that offer quality improvement through peer review.
- The Chartered Society of Physiotherapy guidelines were followed in all the medical notes we reviewed.

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- Staff on the wards and within theatres reported following local guidelines to assist them in the day-to-day management of patient care. Examples included a number of enhanced recovery pathways, medication prescribing guidance in bariatric surgery and guidance in pain management and antimicrobial prescribing.
- Local audit activity at ward level included the Safety Thermometer. In addition to this, we saw where audits had been undertaken in other areas. For example, controlled drugs, resuscitation equipment, moving and handling and privacy and dignity. Audit results were displayed on all the ward areas and we saw where actions had been implemented as a result.
- During our inspection, therapy staff told us they did not undertake any local audits to assess the effectiveness of therapy given to patients.

## Pain relief

- Nursing staff were required to use a pain assessment score to assess the comfort of patients both as part of their routine observations and at a suitable interval of time after giving pain relief. For those patients unable to verbalise their pain an adapted pain scale was used based on the Abbey Pain Scale.
- Nursing records we checked demonstrated where staff were identifying the patients level of pain. However, not all staff were evaluating the effects of pain relief on a consistent basis. This inconsistency had been identified to us previously through our discussions with the acute pain team.
- Patients had a range of options available to them for managing their surgical pain both pre and post operatively. Within unscheduled care we saw where patient-controlled analgesia (PCA) was used to manage the effects of pain in patients who for example, had experienced chest trauma or pancreatitis.
- NICE guidance 'Patient Group Directions (PGD)' (2013) was followed. This allowed registered nurses to supply prescription-only medicines to patients, without individual prescriptions. PGD included paracetamol, Codeine, Buscupan and Entonox. This allowed for a timely response to patients pain without having to wait for a doctor's prescription.
- The surgical division had access to an acute pain team consisting of two consultants, two WTE band 7 registered nurses and a part-time (32 hours) band 6 registered nurse. Out of hours support was provided by

an on-call anaesthetist. We were told the pain team primarily supported the surgical division, but was available to give telephone support and advice to other specialties. For example, medicine and palliative care.

- The nurses within the acute pain team told us they would review the operating lists on a Monday for the following week. This allowed them to identify any issues or those more complex patients that may require additional support with their pain management. The team would also follow up those patients admitted to, or discharged from, the critical care areas of the trust.
- None of the patients we spoke with during our inspection identified any concerns with the management of their pain. Results from an inpatient survey conducted six weeks post hip or knee replacement showed over 90% of patients thought they had had enough pain relief while in hospital.

## Equipment

- Staff on the wards and in theatres reported having enough equipment to enable them to carry out their duties. They reported no difficulties in obtaining additional equipment when required.
- On ward 205 alternating pressure relieving mattresses were available on every bed. The ward manager told us this was necessary due to the age and dependency of patients admitted to this ward. Where this pressure relieving equipment was not required staff would downgrade the pressure relieving requirements.
- In theatres there were well stocked storage areas managed by a nominated member of staff. A log book was also in use to monitor equipment loaned out of theatres to other areas.

## Nutrition and hydration

- Across the surgical division, we saw that patients were screened for malnutrition and the risk of malnutrition on admission to hospital using the malnutrition universal screening tool (MUST). Care plans were in place to minimise risks from poor dietary intake, as appropriate. We saw that evidence of care plans were regularly evaluated and revised, as appropriate, as patients progressed through their care and treatment.
- Staff told us they had good access to dietetic support and had a dietician linked to the ward. We were told referrals were made electronically.
- Protected meal times took place on all the wards we visited. This allowed patients to eat without being

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interrupted and meant staff were available to offer assistance, where required. We observed all staff, including Allied Healthcare professionals and medical staff adhering to protected meal times.

- Staff told us sandwiches and drinks were available day or night. During the daytime, staff reported sending to the kitchen for a hot meal if patients had missed the main meal time.
- Nursing staff mostly followed guidance on fasting prior to surgery, based on best practice guidance from the Royal College of Nursing (2005), which indicated healthy adults could eat up to six hours prior to planned surgery and drink water two hours before. However, we were told of instances in which the anaesthetist decided on the fasting time when patients were waiting a long time for theatre. Staff told us that sometimes lists were changed and, as such, there was often a reluctance to allow patients to drink up to two hours before in case their surgery time was to be brought forward.

## Patient outcomes

- The trust reported data for the 'Summary Hospital-level Mortality Indicator' (SHMI). The SHMI is the ratio between the actual number of patients who die following treatment at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. Trust data for the year to April 2014 was shown to be worse than the national average of 100 at 104.9. However, data for April to June 2014 showed a significant reduction, with June's SHMI reported to be 91.14, indicating that the outcomes for surgical patients were moving towards expected ranges.
- Hospital Standardised Mortality Ratios (HSMR) are a measure used to assess the ratio of the actual number of in-hospital deaths in a region or hospital to the number that would have been expected based on the types of patients a region or hospital treats. The trust HSMR value for the last 12 months to July 2014 was 102.9, which was not significantly worse than the national average of 100. A review of recent data showed that, while the HSMR had been slightly worse than the national average since April 2014, no month had been significantly worse.
- The trust contributed to the national hip fracture audit in 2013. The report indicated worse than average scores for diagnosis of a hip fracture, preoperative assessment by a geriatrician and a bone health medication assessment. The trust performed better in seven out of ten areas as follows; admitted to orthopaedic care within four hours; surgery within 36 hours; surgery within 48 hours; patients developing pressure ulcers; fall assessment; mean length of acute stay and; mean length of post-acute stay.
- The trust's performance in the national lung cancer audit 2012, which looked at the care delivered during referral, diagnosis, treatment and outcomes for people diagnosed with lung cancer and mesothelioma showed the trust to be better than the England average for all 3 areas as follows; discussed at MDT; patients receiving CT before bronchoscopy and, receiving surgery all cases.
- From December 2013, data was being collected on an on going basis for the National Emergency Laparotomy Audit (NELA). The report was not available at the time of our inspection, although we saw where 23 out of 28 measures had been reported and included measures such as: fully staffed operating theatre availability 24 hours a day, seven days a week, consultant pathology advice 24 hours a day, seven days a week and a policy for deferment of elective activity to prioritise emergencies.
- The National Bowel Cancer Audit report 2013, included data from this trust. The report referred to patients diagnosed between 1 April 2011 and 31 March 2012 and data was submitted prior to December 2012. In the trust quality report for 2013/2014 the trust raised concerns that the data was unreliable, due to insufficient numbers of their cases having been included. Results indicated worse than England average scores for discussion at MDT; being seen by a clinical nurse specialist and; CT Scan reporting.
- Patient Reported Outcome Measures (PROMs) for the period April 2013 to December 2013 indicated a decline in patient outcomes for groin hernia and hip and knee replacement. We saw where PROMs had been identified as an 'elevated risk' on the trust risk register and had been discussed at the theatre risk group meeting for November 2014.
- We reviewed information on comparative surgeon outcomes submitted to the National Joint Registry (NJR). Data submitted from April 2003 to July 2014 demonstrated that the 90 day mortality rate following knee and hip surgery for this trust, based on the type of patients seen, was in line with the national average.
- Across the surgical division, we saw that there were arrangements in place that aligned to the Royal College

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of Surgeons (RCS) standards for unscheduled surgical care and emergency surgery. Examples included a dedicated surgical assessment unit, a consultant-led service with consultant availability at all times for telephone advice, a dedicated surgical team free of elective commitments when covering emergencies and emergency theatre availability at all times.

- Readmission rates for the top three surgical specialties, based on activity at the trust, indicated a slightly higher than national average rate for elective activity within general surgery and urology and non-elective general surgery. However, elective and non-elective activity within trauma and orthopaedics and, non-elective activity within urology demonstrated that there were less readmissions than expected when compared with the England average.
- Length of Stay (LOS) for elective and non-elective patients was reported to be in line with the England average.

## Competent staff

- Appraisals in the surgical division completed up to August 2014 were reported to be 84.4% overall.
- All the staff we spoke with described their appraisal as a positive experience and a process that enabled them to identify their learning needs for the following year.
- Therapy staff received monthly supervision. Staff told us they had one hour 'protected' time, which contributed to their continuing professional development.
- Staff told us they attended a corporate induction and local induction when they commenced work at the trust. The trust target for attendance at the corporate induction was 95%. Eighty-eight per cent of relevant staff, within the surgical division, had attended the trust corporate induction in the last year.
- In theatres, staff followed the National Association of Theatre Nurses (NATN) guidelines. We saw that there was a dedicated nurse educator who had responsibility for staff training. New starters to theatres received between six and 12 months mentorship, completed a theatre-specific training pack and had a number of competencies to achieve within the 12 months. For example, new staff would be required to perform the scrubbing up procedure alongside their mentor until they were considered competent. Following their 12 month mentorship period staff would be moved around the specialties within theatres.

- Surgical staff had access to non-mandatory training relevant to their roles. For example, we were advised that staff in theatres had been trained to assist in the use of a robotic surgery devices used for urology and colorectal patients. We were told team training, both face-to-face and online, had been provided by the manufacturers.
- Staff on the wards had access to pain management training, including the use of patient controlled-analgesia and epidurals. On the elective procedure unit, nurse-led discharge training was provided by the unit managers for all nurses who had been qualified for a year or more.
- Junior medical staff reported a positive learning environment, with weekly emails from heads of divisions with learning points, Friday drop-in sessions with the medical director and consultants who were keen for junior doctors to have as much learning experience as possible.

## Multidisciplinary working

- A multidisciplinary team approach was evident across all of the surgical divisions. We observed good multidisciplinary team working on the wards we inspected. We observed therapy staff assisting with patient therapy sessions through encouragement of mobilisation and self-care activities and saw that therapy staff contributed to daily 'board' rounds with the nursing staff.
- At the junior doctor focus group, multidisciplinary team working was described as "very good", and "I've found it fabulously supportive as a junior doctor", and "we all work together so well" as well as "I've never seen such good multidisciplinary team working".
- We observed a ward 'board round'. This included the nurse in charge, the matron, a member of the therapy staff, a doctor and the bed manager. We saw where each patient's condition and progress was discussed and their predicted date for discharge was reviewed on a daily basis.
- Where surgical patients were outliers on other wards, the surgical teams used 'weekend stickers' in the patient notes. These included brief details of the patient, if they needed a weekend review, if they could be discharged over the weekend and any outstanding tasks. Doctors told us they liked it: "It's an efficient summary and really helpful."



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## Seven-day services

- A general surgery consultant was available 24 hours a day, seven days a week.
- The surgical assessment unit (SAU) had a consultant based on the unit, as part of the emergency surgery ambulatory care (ESAC) service, between the hours of 10am and 6pm.
- However, staff told us this post was filled on an ad hoc basis only, with no dedicated consultant for this service. For the month of December, we saw that there was no 'spare' consultant availability for ESAC.
- Consultant-led ward rounds took place daily as a minimum, including weekends, in all ward areas with the exception of the elective procedure unit, where care was nurse-led.
- On the urology ward and the surgical assessment unit, twice daily ward rounds took place during the week.
- Surgical outliers were reviewed regardless of location as part of the routine. An electronic list of all outliers was managed by either the registrar or consultant and would be updated on an ongoing basis.
- Therapy services were available seven days a week from 8am to 6.45pm. On-call arrangements were also in place with therapy staff pre-arranging 'callouts', where possible.
- The acute pain team was available Monday to Friday, 8am to 4pm with on-call anaesthetic cover for out of hours, including weekends.
- Nursing and medical staff told us they had good access to radiology and imaging. However, where there were wards without a band, four assistant practitioners, staff sometimes felt it was difficult transferring patients especially if the ward was busy or short staffed.
- On the surgical assessment unit, hourly dedicated ultrasound slots were available for emergency patients with three additional slots available for non-urgent scans.

## Access to information

- Information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way. Procedure specific information was available in paper format and via the trust online communication system. We also saw where information had been printed off and included in the nursing notes to use as a guide.

- We received mixed feedback from therapy services. Most staff reported good access to the trust intranet for relevant policies and procedures. However, some locum therapists did not have access and had been told access was considered non-essential.
- We saw in theatres where an online, real-time communication system was used. This allowed staff to track patient journeys through theatres and contributed to the management of theatre schedules.

## Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- Staff told us they were aware of, and had access to, the trust policy and procedures for consent. 'A guide to your consent form' patient information leaflets were available in the ward areas. Consent was sought from patients prior to the delivery of treatment. Patients we spoke with told us that they felt involved in decisions about their care. Consent was recorded in all of the notes that we reviewed.
- Most staff we spoke with demonstrated a good understanding of their responsibilities regarding the Mental Capacity Act 2005 and knew what to do when patients lacked the mental capacity to give consent for themselves.
- We saw that a mental capacity assessment was included as part of the admission assessment process with a prompt for staff to consider use of the FACE Mental Capacity Assessment document where any important decision needed to be made.
- In day case theatre recovery, additional information regarding vulnerable adult concerns that had been identified at preoperative assessment, would be phoned through to recovery and the details recorded in the team diary.
- We did not see any Deprivation of Liberty Safeguards authorisations in place during our inspection.

## Are surgery services caring?

Good



Surgical services at this trust were caring. Patients were extremely positive about the quality of the care and treatment they were receiving and with the approach of the staff. Across all wards and departments we saw staff treating patients with dignity and respect.



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## Compassionate care

- Patients were consistently positive about their experience within the surgical division. Patients told us they were treated with dignity and staff were caring. One patient told us, “I wouldn’t want to go anywhere else”.
- We observed staff treating patients respectfully and with dignity throughout the surgical division. All staff were welcoming towards patients and supported them in a professional and sensitive manner.
- On one ward we observed a positive interaction between the nurse and a patient with mental health problems. The patient was visibly agitated. The nurse sat with the patient and talked with them about their plans for discharge and their current medication. The patient had not taken his usual medication, the nurse encouraged them to do so and remained with the patient until they were less agitated.
- On most wards we visited we saw where NHS Friends and Family Test scores were displayed alongside comments made by the respondents. Examples of comments written were: “extremely warm, welcoming staff”, and “lovely atmosphere”, and “very kind”, and also “very helpful”.
- **Understanding and involvement of patients and those close to them**

We spoke with two patients following a consultant ward round. They felt their privacy had been met and had a good understanding of their plans of care. One patient told us that there was a “good explanation of treatment” and that they felt like the doctor was talking to them as an individual.

- We observed one patient returning to the ward following an operation. The patient was anxious and in pain. The nurse administered pain relief and spoke with the patient in a calm and reassuring manner. We witnessed the nurse returning to the patient on two further occasions during our time on the ward.

## Emotional support

- Chaplaincy services provided spiritual and emotional support for patients and relatives and were also accessible to staff if required.
- A designated bereavement service was available at the trust to provide a sensitive, empathetic approach to the individual needs of relatives, at their time of loss.

- Patients and staff had access to clinical nurse specialists across the surgical division. For example, we saw that there were specialist nurses for ascites (excessive accumulation of fluid in the abdominal cavity), drug and alcohol and the acute pain team.

## Are surgery services responsive?

Good



Overall surgical services were responsive to patient’s needs.

Access to care and treatment was monitored and was mostly in line with the national average. Where delays had been identified the trust were aware and had measures in place to address delays. However, delays on the surgical assessment unit with the review of urology patients had not been addressed.

Staff demonstrated a good awareness of the trust complaints procedure and how to deal with complaints. We saw many examples of positive feedback from relatives through cards and comments.

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

- The main challenges within the surgical division related to referral to treatment times and the high volume of surgical activity in both emergency and elective care.
- Service planning around these areas had included multidisciplinary enhanced recovery after surgery (ERAS) pathways in a number of specialties. Examples included; hip and knee surgery, partial gastrectomy, total gastrectomy, hemi-colectomy, breast surgery, radical prostatectomy and, oesophagectomy.
- Senior managers told us ERAS had helped reduce length of stay with 50% of patients undergoing hip or knee surgery being discharged within three days of surgery. Further planning included the opening of a 24-bed elective procedure, 23-hour ward facility to provide short stay, nurse-led discharge for appropriate patients.

## Access and flow

- Bed occupancy was 85.8% for April to June 2014 and 83.6% for July to September 2014, which was better

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than the England averages for the same periods. It is generally accepted that, when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients.

- Emergency patients were admitted to the trust via their GP, or directly through the emergency department. Staff told us that, of the patients admitted through the emergency department, approximately 50% would be discharged with the remaining patients admitted to the surgical assessment unit via the surgical coordinator.
- Urology emergencies referred via their GP were admitted directly to the surgical assessment unit where they would be seen by a foundation year one (F1) doctor and/or the registrar. However, staff told us that patients admitted after the morning ward round would often not get a consultant review until much later in the day.
- On the day of our inspection, a urology patient had returned at 8am for a review of tests carried out the previous day. At 5pm the patient had not been seen by a senior member of the urology medical team. We discussed this with the unit manager, who told us that, due to elective commitments, senior doctors were often unable to review urology patients in a timely manner.
- Most patients we spoke with on the surgical assessment unit were satisfied with the referral process they had experienced and felt they had access to a hospital bed in a timely manner. However, one patient told us, "I appreciate the doctors are busy, but I'm fed up of waiting, this is my third time here in a week." We saw that this patient was waiting for a member of the medical staff to review their test results.
- The emergency surgery ambulatory care service on the surgical assessment unit involved referrals directly from the GP to the surgeon on-call. We were told that this enabled GPs to discuss individual patient cases and surgeons to provide expert advice and sometimes prevent admission to the trust. The service was piloted at the trust in 2012 and data from that time showed a 40% reduction in emergency surgical admissions. Staff told us the service had continued, but was now a sporadic service that relied upon the availability of a 'spare' consultant.
- Between March 2013 and July 2014, referral to treatment time (RTT) performance was consistently worse than the England average. The trust was not meeting the 90% standard of admitted patients who should start consultant-led treatment within 18 weeks of referral in seven out of eight surgical specialties. We discussed this with senior managers, who identified RTT as a significant challenge. They told us that, through transformation work involving enhanced recovery pathways and additional beds on the elective procedure unit, good progress had been made with the reduction of the number of patients waiting longer than 18 weeks for treatment.
- We saw that RTT waiting lists had been reduced by 35% at the time of our inspection. We reviewed NHS England data for December 2014 which indicated five specialties RTT waiting lists had reduced and, three specialties were performing better than the 90% standard.
- Theatre usage was reported to be 74% for August 2014, but had remained stable for the year up to August 2014, and averaged between 78% and 81%.
- The trust contributed to the College of Emergency Medicine Fractured Neck of Femur Audit. Results from the latest audit in 2012/2013 showed the percentage of fractured neck of femur patients seen and operated on within 48 hours of admission was in line with the England average at 85%.
- The total number of elective operations cancelled on the day between March and November 2014 was 269. We noted a downward trend of cancellations over these months.
- Nursing and theatre staff gave examples of reasons for the cancellation of elective activity to be the unavailability of postoperative ward or critical care beds, priority was given to emergency surgery and the overrunning of theatre lists.
- NHS England data reviewed for June to November 2014 indicated that no urgent operations had been cancelled by the trust during this period.
- A 23-hour elective procedure unit was available for those patients undergoing uncomplicated surgery where a predicted length of stay was no longer than 23 hours. The unit allowed for an increased flow of patients through the surgical pathway and, as a nurse-led unit, patients did not have to wait for a medical review before discharge. Using specific admission criteria, the nurse coordinator for the unit reviewed the theatre lists each day to identify suitable patients.
- We observed good discharge processes throughout the surgical division. We saw that discharge arrangements commenced at the start of the patient's surgical pathway and included an expected discharge date.

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- We saw a multidisciplinary approach to discharge planning that included contributions from therapists, pharmacy, social services, specialist nurses and the patients' own GP. Therapists told us of the 'virtual ward' and described a supported earlier discharge process for patients to continue their therapy and nursing assessment at home when they no longer need acute care.
- Within vascular surgery we saw that weekly discharge audits demonstrated 90% of discharges went ahead as planned. We were told that 10% failed and this was mostly due to either medical deterioration of the patient, or waiting for a social care package.
- Nursing staff told us there were surgical outliers at times (patients who are not placed on the surgical specialty ward). For example, staff told us that surgical outliers were frequently placed on the urology ward. Generally, staff did not feel there were any issues with medical reviews of outliers.
- We were told that weekend reviews sometimes did not take place until the afternoon. This meant patients who could be discharged were not leaving the trust until later in the day. In order to assist with the medical management of patients, including surgical outliers, we saw where 'weekend plan' stickers were inserted in the medical notes. Examples of information that appeared in the weekend plan included: a summary of treatment given, essential jobs that needed to be completed and investigations that needed reviewing.

## Meeting people's individual needs

- Interpreters were accessible either face-to face or via telephone service, All the staff we spoke with told us interpreting services were easy to access.
- A learning disability specialist nurse was available in the trust. Staff told us the nurse would usually be aware of the patient's admission and would visit the patient to offer support and advice.
- We noted during our inspection patient information leaflets available in clinical areas and on the trust website were all in English. We asked nursing staff if leaflets were available in other languages. Most of the nursing staff we spoke with thought leaflets could be translated but were unsure of the process to do so.
- Within the surgical division the trauma and orthopaedic ward had been identified as a recognised ward for those patients living with a dementia related illness.

- We saw the ward had a reminiscence room designed to help improve the mental wellbeing of the elderly patients and patients with dementia. The patients we saw in this room were calm and relaxed and had nothing but positive comments to make about this facility.
- Throughout the ward we saw pictorial signs which helped those patients living with dementia to interpret the different areas of the ward and therefore help them to find their way around. Nursing staff told us they were also in the process of developing a 'snug' area on the ward to allow a meaningful area for those patients who preferred to wander around the ward.

## Learning from complaints and concerns

- Across the surgical division we were shown examples of compliment letters and saw comments displayed in ward areas.
- We saw there was a complaints procedure on display in all of the wards and staff told us the process for dealing with complaints which included local resolution in the first instance.
- Ward managers told us complaints would be discussed at ward meetings and learning points would be identified.
- Complaints relating to surgery accounted for the second highest number in the trust with a total of 57 complaints relating to surgical specialities. Fifty-three percent of complaints within surgery related to provision of care. The top three areas where complaints had been raised were surgical assessment unit (five complaints), general surgery theatre (four complaints) and Ward 307 (four complaints).

## Are surgery services well-led?

Good



Surgical services were well led. Staff felt valued and listened to and felt able to raise concerns.

Measures were in place to manage risks throughout the surgical division and we saw effective governance arrangements in place involving all staff throughout the service.

# Surgery

Across the surgical division we saw that staff were committed to providing safe and caring services. There was mutual respect amongst staff with senior managers having high praise for their staff.

We saw where innovative practice within the surgical division was contributing to positive outcomes for patients and staff were proud to tell us of developments within their individual areas.

## Vision and strategy for this service

- The trust vision 'Taking pride in caring' was visible throughout the surgical division. Staff demonstrated an awareness of the vision and the values of the trust.
- Staff we spoke with were passionate and committed to ensuring patients received the care and treatment they needed.
- The trust had an operational plan prepared in line with Monitor's guidance which set out how the trust intended to deliver services for patients over the next two years. We saw where elective and emergency surgery provision had been included in the operational plan with an emphasis on improving operational performance in access targets and quality measures and, a review of both elective and urgent pathways.

## Governance, risk management and quality measurement

- All staff across the surgical division demonstrated a good awareness of governance arrangements.
- Within theatres an electronic risk register was maintained and risks identified were discussed at a monthly theatre risk group meeting chaired by the divisional nurse director for surgery.
- Our discussions with senior managers showed they were aware of the main risks and challenges for the surgical division. For example, we saw where the referral to treatment times had been highlighted as a significant risk for the trust.
- Sharing of Never Events and serious incidents took place at local governance meetings and information discussed contributed to the trust quality review committee.
- Within anaesthetics, staff were able to identify risks to their services and gave examples of a decreased allocated governance time, incident reporting feedback and, vacancies.

- Most nursing staff told us they attended monthly ward or department meetings. Ward managers told us they attended divisional ward manager meetings and had regular one to one meetings with their line manager. These meetings allowed staff to be updated on organisational changes and developments, discuss specific matters and concerns, receive feedback on incidents and participate in shared learning.
- Therapy staff reported having monthly meetings to discuss issues and risks within their services. We saw where a more structured training programme and, an increase in medical outliers had been discussed. However, locum therapy staff we spoke with told us they did not have the opportunity to attend team meetings and were not therefore always made aware of current issues within therapy services.

## Leadership of service

- The NHS Staff Survey 2013 saw the percentage of staff in the trust reporting good communication between senior management and staff and support from immediate managers as being within expectations when compared with other trusts.
- Most staff from a range of various surgical related roles described senior managers within the surgical division as being approachable, visible and committed to ensuring care delivery. They also said that the culture within surgery was patient-focussed.
- Staff reported 'back to floor' visits and that the chief executive working alongside staff during a shift. However, some staff felt the 'back to the floor' visits were audit related and did not necessarily engage with frontline staff.
- The senior managers within the surgical division had high praise for their staff and recognised the challenges staff within the surgical division faced especially with the increasing demand on surgery.

## Culture within the service

- Across the surgical division staff consistently told us of their commitment to provide safe and caring services. Overall we saw good morale amongst staff and staff spoke positively about the care they delivered. Generally staff felt listened to and involved in changes within the trust.

## Public and staff engagement

# Surgery

- All the staff we spoke with assured us they understood the trust whistleblowing policy and would feel comfortable using it if necessary.
- The NHS Staff Survey 2013 saw the percentage of staff recommending the trust as a place to work or receive treatment was within expectations when compared with other trusts.
- The Pride of Derby awards celebrated the inspirational work of the trust's staff members and the value they added to the trust. Throughout the surgical division, we saw Pride of Derby nomination certificates displayed in clinical areas. We saw that, in September 2014, staff in the surgical division had received awards for 'best team' and 'inspirational leader'.

## **Innovation, improvement and sustainability**

- We saw that innovative practice within the surgical division was contributing to a positive outcome for patients.
- In theatres, a robotic surgery device had been introduced for patients undergoing complex cancer operations. We were told the robot allowed surgeons to carry out highly complex operations with three

dimensional vision and greater surgical accuracy. Early patient feedback we saw demonstrated that the recovery time following this type of surgery had been reduced. The robot was currently being used in urology and colorectal surgery, but was to be rolled out to other specialties including gynaecology and head and neck cancers in the new year.

- In the anaesthetics department, anaesthetists had introduced the use of prilocaine spinal anaesthetics in day case surgery. This was used as an alternative to the more traditional bupivacaine anaesthetic. Staff told us this allowed spinal anaesthetic to be used on the afternoon theatre lists without increasing the need for an inpatient admission following surgery.
- Transformation work around the emergency surgical pathway had seen the introduction of a portering service on the surgical assessment unit allowing nursing staff more time to deliver direct patient care rather than having to transfer patients to other wards.
- Allocated theatre slots had been agreed in theatres for those patients requiring emergency surgery on their gall bladder. This reduced the length of time these patients were waiting for their surgery.

# Critical care

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

## Information about the service

The intensive care unit (ICU) had 20 bed spaces available. Staff in the unit cared for patients who were categorised as level 2 or 3. Such patients had failure of, and required support for, two or more major organs, and may have required technical interventions such as closed ventilation or medication to support the heart and circulation. The staffing levels met national guidelines of one nurse for each level 3 patient and one nurse caring for two level 2 patients. Beds were only occupied if appropriately qualified staff were available. Sixteen beds were in use during our visit. There were laminar flow side rooms which meant a controlled air flowed through the rooms so that patients with infection or at high risk of infection could be cared for safely.

There was an outreach service provided by experienced critical care nursing staff. This meant that patients who had been discharged from intensive care or those patients on the wards who were thought to be deteriorating could be assessed, monitored and treated to maintain safe care in ward areas. Patients were also offered appointments with a specialist nurse to support them after the experience of being cared for in intensive care.

The hospital had high dependency units (HDUs) in three ward areas. The renal and medical high dependency areas cared for some patients who were level 2 category and may have required kidney dialysis. In the other HDUs there were patients with respiratory or stroke conditions who were level 1, high care category.

During our inspection we visited the intensive care unit and step down ward. We also visited the renal, stroke and respiratory high dependency units. We spoke with 50 members of staff, nine patients, five relatives and examined six care records.



# Critical care

## Summary of findings

There were safe levels of medical and nursing staff, and staff were supported to develop and maintain clinical expertise.

Competent medical, nursing and other professionals worked effectively together to ensure safety. There was one never event in the week prior to our visit which was fully investigated, procedures were amended and information cascaded to staff to reduce future risk.

All patients and relatives we spoke with told us that staff were supportive, efficient and caring. The service provided follow-up arrangements for patients who had been cared for in intensive care to reduce emotional and psychological distress after their experience. There was effective clinical leadership and managers worked closely to support improved patient care. Clear plans, protocols and procedures meant that the staff were aware of their responsibilities.

Arrangements for the management of level 2 patients in the high dependency units did not meet national standards. There was daily review by medical consultants but there was no routine involvement or support from intensive care consultants. Nursing staff were working to competency frameworks relevant to their specialty but few had critical care qualifications. Audits of performance, and outcomes for patients, in the high dependency areas were not compared against similar care units nationally.

## Are critical care services safe?

Good



There were safe levels of medical and nursing staff, and staff were supported to develop and maintain clinical expertise. There was close monitoring of incidents and staff were kept informed of learning from any investigations. Audits of safety indicators took place and we saw that infection prevalence was low compared with other units. There were clear comprehensive records of care, and good arrangements to deal with additional pressures of activity or major incidents.

There were appropriate checks by staff to ensure safety in use of medication. However the ICU did not use the general hospital electronic prescribing system so there remained a risk of poor communication about medications administered prior to admission to ICU.

### Incidents

- Incidents were reported using the trust's electronic reporting system. Staff described the procedures used to report incidents on the system. They described the logging process as cumbersome due to the many drop down boxes to be filled in. However all staff stated they understood the need to report incidents to ensure learning and provide accurate record of performance.
- The service was able to provide a summary of information about incidents. There were 158 incidents from December 2013 to December 2014. Of these only six were coded as moderate impact with all others being minor or no impact. Of the six moderate incidents, four incidents were pressure ulcer reports, one was a potentially serious infection risk to staff, and the other incident was a medication error. We saw that all incidents had been reviewed and action points approved and recorded.
- We examined reports of incidents from the intensive care unit for 2014. Reports were predominantly of minor incidents showing that the clinical staff report incidents of a low level to ensure learning, even from near misses, and incidents categorised with insignificant actual impact. We saw that pressure ulcers were included in

# Critical care

the reports even where these were found on admission to the unit. This was evidence of detailed reporting to determine root causes of issues that affect patient care and comfort.

- Medical staff told us they were not always involved in the investigation and feedback processes. However, incident reports had been provided in team meetings, risk meetings and on noticeboards in the department. At shift handover meetings there was a section called 'spread the word' at which important messages including learning from incidents were shared with nursing staff.
- There had been a never event in the days preceding our visit which had been investigated and staff had implemented processes to reduce the risk of reoccurrence. This was a medication error but the effects had been dealt with rapidly to protect the patient.
- As a result of the incident, the service had implemented changes to the timing of morning blood tests to ensure results would be available earlier in the day and would inform prescription of that specific medication. In addition, there were plans to introduce different colour trays to carry the medication concerned, to remind staff to check dosage.
- Mortality and Morbidity meetings were undertaken monthly by the clinical teams in ICU and HDUs.

## Safety thermometer

- Safety and quality audit results were displayed in the public corridor entering the unit. The information for 2014 showed that the adherence to procedures for preventing infection in intravenous cannulas was 85% in January 2014 and had improved to 89% in November 2014. Data displayed was accompanied with notes to staff to improve performance such as improved labelling of fluid giving sets. This showed that audit and data was used in the unit to improve performance and safety for patients. In addition the public display showed performance on completing documentation and
- Staff described the infection control audits that were made regularly including observation of staff hand hygiene procedures.

## Cleanliness, infection control and hygiene

- The Intensive Care National Audit and Research Centre (ICNARC) data showed low levels of infection rates in

ICU. The report showed no MRSA or C.diff infections for the survey period January to March 2014. Audit information displayed showed that the service had reported one recent patient having a methicillin sensitive Staphylococcus aureus infection (MSSA). Staff were able to explain the individual circumstances of this case. Patients were cared for in a clean and hygienic environment. The ICU had four single rooms with laminar air flow to prevent airborne infection risk passing to other patients in the unit

- We saw that there was a dedicated housekeeper for the unit who followed cleaning schedules and worked closely with the clinical team. Technical equipment was cleaned by all staff including health care assistants who were trained and assessed competent to undertake specialised decontamination of scopes using steriliser systems.
- We observed that staff followed the trust policy on infection control. The 'bare below the elbows' policy was adhered to. We observed staff using gloves and aprons, and changing these when moving between rooms where patients were being cared for due to infection risk. Visitors were reminded by staff to gel hands clean when entering the units. There were adequate hand washing facilities throughout the departments, and personal protective equipment (PPE), such as gloves and aprons were available.

## Environment and equipment

- The intensive care unit was spacious, clean and tidy on all our visits.
- Staff told us that equipment was available for use as required and well maintained.
- The intensive care service had a charitable fund through which additional equipment was purchased when this was needed for patient care. The fund also supported teaching and research. Staff told us this meant there was modern equipment ready for use when needed.
- We spoke with medical engineering staff who described regular sessions where engineers were based in the department for routine equipment checks and maintenance.
- Some electronic and other equipment had stickers showing that service checks were due but staff told us that equipment was reliable and replaced immediately when needed.

# Critical care

- Resuscitation equipment and trolleys in ITU and on the HDUs were well stocked and had been checked daily according to checklists. This included the suction and defibrillator equipment on the trolleys.
- In ICU there was additional advanced airway management stocks available for immediate use with a range of intubation equipment to support difficult airway management situations.

## Medicines

- The ICU did not have an electronic prescribing system as provided in the rest of the hospital. This was identified as a contributing factor in recent drug errors incidents. This was because it was not always obvious if patients admitted to unit had been given medications. The general hospital system had not been developed to support the activity in ICU. The risk was reduced as all staff had been made aware but systems had not amended. The trust had received funding from the Safer Hospitals Technical Innovation bid for an integrated system linking electronic prescribing with patient observations and management. The trust told us this would allow for safer management of critical care patients.
- Staff kept accurate records of medication administration. Prescription charts were clearly written and completed. We observed that staff checked medication with each other as needed, including flow rates for medications infusions and filtration rates at bedside handovers between shifts.
- Medicines in some areas were not fully secure. We spoke with managers about this and they undertook to ensure safer storage arrangements. On a later visit by our inspectors we found the storage to be secure. Staff required easy access to some medication stocks in emergency situations and therefore some medications were held in the clinical area ready for use including those in emergency trolleys. Controlled drugs were safely and securely stored.
- We spoke with pharmacy staff who audited medication administration and appropriate medication usage. This provided secondary safety checks and support to clinical decision making by medical and nursing staff
- We examined records showing that fridge temperatures were monitored daily in the ICU and HDUs to check that medicines were stored at appropriate temperatures.

## Records

- We examined documentation kept in the treatment bays and medical records. We examined seven records in detail. There was good evidence of patient assessments, team discussions, plans of care and care provided.
- There were detailed records for each day including a review of each bodily system, pain and sedation, medication reviews, infection or sepsis status, and the current plan of care.
- Observations were taken and recorded at the required frequency including ventilator observations. Charts were kept up to date for observations and medications administered.
- The different professionals involved in the patient's care entered their assessment in the records to allow the team clear access to information. There were daily physiotherapy and dietician review notes. Nursing records for the shift were kept on a daily observation and record sheet covering different body systems and patient needs. Each patient had a completed set of admission booklets.
- Audit data for ICNARC was recorded by staff in admission and transfer records. Blood test results were recorded on paper records from the computer system so they were available for review at the bedside.
- Risk assessments were made including pressure ulcer risk and central venous and other vascular access points to monitor for infection.
- There were clear records of discussions with the patient's relatives or carers on a communication record sheet and within medical case notes. This included any agreed resuscitation plan where this was appropriate.

## Safeguarding

- Staff were aware of procedures for safeguarding of vulnerable adults and their responsibilities.
- Training records showed all staff had attended relevant sessions about safeguarding.
- Incident reports shared with managers and all staff included all issues of minor impact and safeguarding or self harm. This meant that reporting was transparent and managers were aware of standards of care and safety in intensive care.

## Mandatory training

- We examined training records and saw that staff had been able to attend mandatory and other key training sessions. Attendance figures for staff in the ICU were

# Critical care

over 90% for infection control, hand washing, moving and handling, and skin integrity. All staff had attended training in risk management, safeguarding, the Mental Capacity Act, and pain management. Rates of attendance for the medical staff in ICU were 80% overall.

## Assessing and responding to patient risk

- There was an outreach team providing support five days a week, from 8am to 9pm for the management of critically ill patients in the hospital. The staff were experienced critical care nurses who could support, advise and audit care of patients throughout the hospital when requested by other wards and through daily checks. Out of these hours the hospital at night team included nurses who liaised with staff in intensive care if patients required assessment for deterioration. Ward staff used early warning scoring on observation charts to identify patients who were deteriorating. The trust had plans for limited initial deployment of electronic tracking of patients' condition which would alert specialist staff to support the ward areas.
- The outreach staff also followed up patients after they had been discharged from the ICU and were on other wards. These patients stayed on a list for outreach staff to visit and support until the staff were satisfied the patients had recovered and their condition was stable.
- We observed handovers between shifts of medical and nursing staff. These were detailed and enabled all staff to be aware of the different patients in the department. Bedside handovers between nurses were in greater detail to include up to the minute status of the patient such as whether the ventilation of breathing was being reduced to allow the patient to breathe for themselves, or the detail of medication and fluid regimes.
- A safety checklist was completed at handover when patients were transferred to ward areas. This was to ensure staff receiving the patient understood the care and key issues of care for the patient at that time.

## Nursing staffing

- The ratios of nurse to patient was maintained for safety and appropriate care, in line with national guidelines.
- In ICU all level three patients had one nurse for each patient, and all level two patients were cared for by one nurse to two patients. There was also a nurse to 'run' on each shift to support staff who could not leave the patient's bedside.

- There was one nurse allocated to care for a patient on a ventilator. Patients having closed ventilation are categorised as level 3 and the national guidance is for a nurse to be allocated solely to care for such patients.
- There were healthcare assistants on shifts to support where patient handling was required and also to undertake technical tasks such as decontaminating and preparing equipment for use. This level of staffing was strictly applied by senior staff to maintain safety for critically ill patients.
- Additional staffing needs to care for more patients, or to cover absences, were met using regular bank or agency nurses. The bank and agency staff had experience of working on the unit and had full induction and orientation as required.
- Staffing was planned well in advance and additional staff secured as needed. The service worked with the regional network of critical care departments in case of not being able to care for all patients requiring intensive care.

## Medical staffing

- There were ten intensive care consultants with no unfilled vacancies. This allowed for 24 hour cover place for the intensive care department.
- Consultants provided cover seven days a week. Medical and nursing staff told us that consultant advice and support was readily available at all times. There were two consultants in the ICU from 8am to 6pm daily. Between 6pm and 8am cover was provided by the consultant on call.
- Patients had a review of their condition and progress by a different consultant each day which allowed for peer review and consideration of issues by doctors with different expertise.
- Patients in ICU were under the care of intensive care consultants.
- Medical team handovers were undertaken twice a day then full reviews took place at each patient's bed space with the multidisciplinary team.
- Consultant trainees from the emergency department had placements for two weeks in ICU, which meant additional medical staff were available and these senior trainees provided additional review and support of patient care.

## Major incident awareness and training

# Critical care

- Staff had good awareness of major incident plans and were able to locate plans on the intranet. They showed us the log of staff contact details used to call additional staff in the event of an incident. Staff told us they had been provided with an overview of emergency plans at trust induction training.
- Senior team staff had attended a major incident planning day in 2014 and told us that revised plans were being prepared. There were action cards for senior medical and nursing staff in the anaesthetic service that covered intensive care. There was an anaesthetist on the trust major incident planning committee.
- The teams had been made aware of seasonal plans including opening additional beds in intensive care. Senior staff told us that these plans would be flexible depending on patient need and in intensive care specifically on nurse staffing to maintain safety.
- Staff had been included in hospital wide awareness of procedures in case of suspected Ebola infection.

## Are critical care services effective?

Good



Nursing staff in HDU were working to competency frameworks relevant to their specialty. The units collated some audit data but did not contribute to the national ICNARC audit. The HDU provided level two care but they were not working in accordance with the Core Standards for Intensive Care Units (2013).

Clinical outcome and service information showed performance was good compared to national data. Infection rates were very low and patient flow was appropriate and safe.

### Evidence-based care and treatment

- We saw that patients had their needs assessed and care planned appropriately according to national standards and guidelines. We saw that guidelines were in use for respiratory distress, antibiotic prescribing, nutrition, delirium and managing infection.
- We found that National Institute for Excellence (NICE) guidelines for the care of acutely ill patients were generally fulfilled. This included having outreach teams, education for ward staff about deteriorating patients, aiming to transfer patients promptly when ready for discharge from ICU and avoiding such transfers between 10pm and 7am.
- Care pathways to maintain safe care were followed to ensure patient care was assessed, implemented and recorded to prevent issues such as infection and pressure ulcers.
- Ward 407 HDU provided appropriate care and support but did not meet the national standards as described in 'Core Standards for Intensive Care Units 2013'. These standards were relevant, as some of the patients who were cared for in the renal and medical HDUs on this ward were level two patients. Patients requiring level two care are those that need more support for one of their organ systems such as the kidneys. They would receive detailed observation and interventions to help their organ recover. Level three patients are those that either have two organ systems failing or they require advanced respiratory support. Level three patients are cared for in intensive care units.
- The Core Standards for Intensive Care Units (2013) apply to all units capable of looking after level 2 or level 3 critically ill patients, regardless of whether they are in a high dependency unit, a critical care unit or an intensive care unit. The standards include an expectation that the service is supported by intensive care consultants, with patients being reviewed regularly and having day to day support by medical staff with intensive care skills such as advanced airway management. Fifty per cent of the nursing team caring for level two and three patients should have a recognised post registration critical care qualification. The outcomes for such patients should be monitored and benchmarked against national audit data for similar units. These standards are accepted nationally as good practice for services providing care for level 2 and 3 patients.
- The HDUs were led by consultant physicians who provided daily review and on call support. However there was no routine involvement or support from intensive care consultants. Nursing staff were working to competency frameworks relevant to their specialty but few had critical care qualifications.
- In the respiratory HDU on ward 403, and on ward 410 HDU where patients were cared for after having urgent treatment for a stroke, the patients were level one patients, and therefore did not come under the core standards.



# Critical care

## Pain relief

- Prescription charts showed that patients had appropriate pain relief and sedations prescribed and administered.
- We spoke with three patients in the high dependency area of intensive care. Patients told us that staff ensured they were kept comfortable and their pain was managed.

## Nutrition and hydration

- Staff assessed the nutritional and fluid needs of patients. There were detailed records of nasogastric feeds, parenteral feeds and vitamins, electrolyte replacement and fluid infusions.
- Staff told us there were occasional delays of several hours in receiving a radiological opinion on x-rays to ascertain the position of a nasogastric tube. Tubes were not used to provide food or fluids for safety reasons until the position was confirmed.
- We saw that dietetic staff were a key part of the multidisciplinary team, taking part where possible in ward rounds and reviewing the nutrition of critically ill patients as a priority in their workload across the hospital.

## Patient outcomes

- Intensive Care National Audit and Research Data (ICNARC) for 322 patients admitted to ITU in the six month period to August 2014 showed standardised mortality ratios were within expected range at 1.0 based on APACHE II and 1.13 based on ICNARC. This meant the unit was providing care appropriately compared to other intensive care units.
- The high dependency units (HDU) collated performance and patient outcome audit data but did not contribute to the national ICNARC audit. The HDU's collected data to predict mortality based on laboratory results and clinical data with the aim of calculating standardised mortality rates. This may not provide an accurate and comparative representation of mortality rates and it was not subject to national benchmarking or external peer review by the local critical care network.
- The intensive care service took part in national audit (ICNARC).

- Data showed that patient flow through the ICU was safe and effective though some patients had delay of discharge to ward areas, this was due to availability of step down beds in ward areas.
- A third of patients were discharged to other high care areas in the hospital. The average length of stay in the intensive care unit was just over four days which was lower than the national average at around six days. However a fifth of patients were delayed in being discharged of four hours or more. This meant that some patients may have been ready for rehabilitation on a ward area and but not had access for example to ward bathing and toilet facilities
- There were very few unplanned readmissions within 48 hours. Two per cent of patients were subsequently readmitted to the unit within 48 hours of discharge, a further 2% were readmitted after 48 hours. These rates were the same as for intensive care units nationally.
- The proportion of patients who died after receiving care in the intensive care was less than the national average for intensive care patients. This shows good performance for the Derby intensive care unit.

## Competent staff

- Forty three per cent of nursing staff in the ICU had a post registration qualification in critical care nursing. This is close to the recommended 50% according to national ICU standards. The standards are regarded as an aspirational framework. We found that the levels of competence and experience in ICU were high and there was close monitoring of competence and effective supervision to manage the patients being cared for.
- The intensive care department had a detailed competency programme for staff to follow. This extended for many months when nurses started work in the unit. Two newly appointed nurses discussed and showed us their detailed competency folder. They said they had been on a one month introduction including shadowing experienced staff and theoretical sessions.
- One nurse who had been working in the unit for over a year told us there were still areas of practice that they would need guidance and more experience in. However they said there was always supervision when needed and support to continue learning.



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- Staff in ICU were grouped in teams, with an experienced nurse leading the team, and were allocated team learning sessions throughout the year to complete mandatory training and additional education related to the complex skills and care they provided.
- Outreach staff provided training sessions for staff throughout the hospital to raise awareness and knowledge about deteriorating patients and specific skills such as arterial blood gas sampling and capillary blood gas levels measurement.
- Regular training provided to other hospital staff included awareness of the needs of acutely ill patients and the use of the early warning scoring system to quickly identify patients whose condition was deteriorating.
- Only the ward Sister and two other staff had recognised qualifications in critical care nursing on Ward 407 the renal and medical HDU. Some patients on this ward were level two requiring higher levels of care, intervention or observation. However nurses on this ward had specific competency booklets to check off the learning of skills, and record the assessment of their competence.

## Multidisciplinary working

- We saw that all relevant specialities were available and involved in assessing and planning care for patients in ICU. All relevant professions were involved in ward rounds and patient reviews, for example microbiologists provided advice and support on management of infections.
- Therapy staff and other professionals such as dieticians worked closely with staff based in the unit.
- Although there were not always exclusive staff available for ICU we saw that there was priority given to time needed by patients in ICU from the physiotherapists, pharmacists and dieticians.
- There was a follow up clinic for patients to return and discuss their experience of intensive care with a nurse consultant. However staff felt there could be more planning and support for other aspects of rehabilitation of patients after discharge from ICU as in NICE guideline CG83.

## Seven-day services

- The outreach teams provided an easily accessible link between wards and ICU so that advice from specialist professionals was available to wards for patients

discharged from ICU, or other patients whose condition was deteriorating. The teams were available each day of the week from 8am to 9pm. Out of these hours a hospital at night team included nurses who were given information by the outreach team about any patients that required close monitoring.

- There were sufficient intensive care consultants to cover seven days, and there was an on call consultant overnight. Staff told us it was always easy to contact a consultant for support and usually this meant the consultant being present to review patients and revise the plan of care if required.
- Overnight there was a doctor based in the ICU with advanced airway management skills and access to consultant advice or attendance if required.
- Staff told us that radiographers were readily available on call to provide x-ray imaging out of hours when needed.

## Access to information

- All observation charts and on-going records were kept by the bedside to enable relevant staff to have timely access to information when reviewing and planning care.
- Staff had easy access to computer systems throughout the ICU. There were some portable computers available for use in bed spaces and to support multidisciplinary discussion rounds.
- Protocols and guidance folders were kept at each bedside for easy staff reference. For example a new scoring record had been introduced prior to our visit to monitor patients for levels of delirium. Explanation and scoring guidelines were available at each bed space.
- There was some duplication of information across admission booklets and between the computer records and paper records.
- Staff told us that there were multiple passwords for them to access the different computer applications with patient information, and that the pathology system was sometimes unreliable meaning they had to telephone the labs for results.
- There were clear arrangements for continuity of care and information when transferring patients to other wards. In addition to the handover at the point of transfer the outreach staff supported the transfer and on-going care until the patient was deemed stable. This

# Critical care

included ensuring key aspects of care were continued on ward areas such as taking and monitoring blood test results and ensuring ward teams had information about relatives and carers.

## Consent and Mental Capacity Act

- Staff were able to explain the requirements for consent to treatment and were aware of capacity assessments where the patient's mental capacity was diminished.
- Staff were aware of the Deprivation of Liberty Safeguards. We saw that senior staff were discussing with their teams about how the law affected how they support patients and families in situations where the patient was sedated during treatment of critical illness.
- We examined care records and saw that there was discussion with relatives about resuscitation where this was relevant for the patient.

## Are critical care services caring?

Good



Patients and their relatives told us that staff in the critical care service were caring and compassionate. Patient satisfaction responses were positive with most patients saying all aspects of the service were excellent.

Patients in the high dependency units we visited also told us they felt well cared for. We saw that staffing levels meant there was close supervision and monitoring of patients requiring intensive care or high levels of care in those ward areas.

The Trust provided a follow-up clinic, at which patients had the opportunity to access support to help them deal with the psychological effects of being cared for in intensive care.

## Compassionate care

- Care was delivered in a compassionate way to patients. We saw staff caring for patients in a kind and professional manner. We saw that the patients were treated with respect and dignity throughout their treatments. Nurses were attentive and had a good rapport with patients.
- Patients provided very positive feedback on the ICU service.

- We saw that patients and relatives were provided with questionnaires to enable feedback on the service. We examined the responses on 89 returned questionnaires. Questions were about staff compassion, consideration of the patient's need, communication, level of support, and the care provided. The majority of answers being 'Excellent'.
- One patient we spoke with described the staff as 'Stars', and that they received 'Excellent care.'

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

- We saw that visiting times were throughout the day allowing relatives or carers to spend time with patients who were in ICU. There was a reception area staffed to enable visitors to be welcomed and guided into the clinical area. We observed that relatives were encouraged to sit close and communicate with patients who were very ill or unconscious. Patients were included in care arrangements such as infection control measures.
- There was accommodation available close to the ICU which relatives of critically ill patients could use to stay overnight.
- Patients had responded to feedback questionnaires by saying the service was excellent at involving patients and relatives in the care provided. Only three respondents from 89 returned patient and relative questionnaires said when asked 'Did you feel included supported during any decision making' said it was 'fair', with over 50% saying this was excellent.
- Case records showed there was discussion with patients and relatives where appropriate. We saw there was detailed discussion with the family about a decision of not for resuscitation. One relative of a patient who had been in for three weeks told us that doctors and nurses spoke with them regularly and kept them fully informed.

## Emotional support

- Patients were given the opportunity to have a follow up appointment or several appointments as needed to discuss their experience in ICU. This allowed patients to be provided with support they may require to help with the psychological trauma of being critically ill. The service was offered to patients during the follow up by the outreach team and patients saw an intensive care nurse consultant for their follow up.

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## Are critical care services responsive?

Good



Staff in the critical care services were responsive to patient's needs. The capacity of the unit meant that patients received timely care and outreach staff provided good continuity when patients were discharged to ward areas.

Staff described how patients with a learning disability or living with dementia would be supported and demonstrated a good understanding of relatives' or carer's needs. The number of beds available was sufficient. We saw that few planned operations were cancelled due to lack of availability of critical care beds.

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

- The ICU worked with the Mid Trent Critical Care Network in managing peaks of workload. The bed availability across the region was reported daily so that where one ICU could not care for a critically ill patient because of bed or staff availability patients could be transferred and cared for in another ICU. We saw in benchmarking ICNARC data that there were no discharges for non clinical reasons in the past year from ICU. This meant that patients had not been discharged too early for example to make way for a more critically ill patient, or due to lack of staff.
- The trust had proposed a seasonal plan for discussion. The plan for increasing capacity over winter included opening beds for level one patients in bed spaces on intensive care, which would free up additional bed capacity on a step-down ward. This was being discussed with managers at the time of our inspection. The limiting factor according to managers was likely to be the availability of specialist nursing staff.

### Meeting people's individual needs

- All patients in the intensive care unit had by definition complex needs which were assessed and managed holistically by the care team. We examined clinical records which had detailed assessment of physiological systems, care needs, and regular observations to manage patient's progress and prevent deterioration of their overall condition.

- Staff had a very supportive approach to relatives, this included the offer of accommodation on site when this would help if a patient was particularly critical.
- Staff told us that if the patient had a learning disability and it was deemed useful the relatives or carers would be encouraged to have greater access and extended visiting to help with communication or reassurance of the patient.
- The staff undertook regular assessment of patient's level of delirium. This was to check for the effects of sedation and sensory deprivation or overload due to the very unfamiliar environment and being cared for intensively.
- These assessments had only been in place for all patients a few days prior to the start of our inspection visit so it was not possible to assess the positive benefits. The intention was to identify those patients at risk of psychological effects of critical care at an early stage.

### Access and flow

- The bed occupancy figures for January to March 2014 show usually 10-15 patients with 17-19 patients for 7% of the time. Most admissions to the unit were unplanned or planned surgical or medical patients with some patients being transfers in from other hospitals, this is managed through the critical care regional network and only occurs when beds and staff are available.
- Admissions to ICU were managed by the team with all patients being assessed by a medical intensivist. Approximately 75% were admitted without being seen in ward areas, these included for example the planned elective cases from operating theatres. Approximately 25% of patients were assessed by the outreach team or medical team. This included some patients who had deteriorated on wards and then agreed for admission to the unit.
- We saw that ICNARC data showed some patients were delayed in being transferred to ward areas. Approximately 60% of patients stayed longer in intensive care than needed, mainly due to bed or staff availability in ward areas. This meant that patients were kept safely under high care although the patient may be ready for rehabilitation in a ward area with less intense support. Staff said this had not caused problems for patients needing to be admitted to the unit.
- All the high dependency units (HDU) in the hospital looked after some patients who had been discharged

# Critical care

from ICU, and some patients where escalation of care to ITU was deemed unnecessary. This meant that the HDUs provided a valuable resource for the management of critically unwell patients within the hospital.

- Patient flow was supported by the work of the outreach team to agree admission, and to follow up patients in ward areas after discharge from the unit.
- All admissions to intensive care were level two or three category.
- Most patients were discharged because they had recovered and did not need critical care any longer or because they could be moved to a bed in the hospital where they could receive a high level of care, such as in the step down ward and other HDU ward areas. Managers and clinical staff told us that the high dependency areas and step down wards were key to managing patient flow and promoting timely discharge from intensive care.
- ICNARC data showed there had been no discharges from the unit for non clinical reasons because the unit could not deal with the number of critically ill patients.
- There were very low numbers of patients who had elective surgery cancelled due to lack of intensive care beds. Management data showed only two such patients since April 2014.

## Learning from complaints and concerns

- We examined the records of nine complaints made about the intensive care service. There were no trends apparent. Staff told us they were made aware of any complaints. Patients and relatives had been offered meetings to discuss concerns where appropriate.
- We spoke with two senior staff who were aware of the Duty of Candour requirements. There had been open discussion with the patient, and detailed records of the recent never event in the unit. This included implementation of learning points and changes in practice.

## Are critical care services well-led?

Good



Critical care services were well led. There was good local leadership in the critical care unit led by a general manager, consultant nurse and the unit sisters. Consultant staff worked effectively to provide strong medical leadership ,

direct clinical cover and education. There was shared learning in the team and support for staff. We saw that staff worked well together, there were clear governance arrangements and staff views were respected.

## Vision and strategy for this service

- There was good planning for the intensive care service. We examined service planning information for the ICU. Plans were based partly on national trends for intensive care such as increases in the proportion of level two patients. Business plans covered issues such as key priorities, financial bids, cost improvement savings, and a workforce plan including the structure of management for the service.

## Governance, risk management and quality measurement

- There were clear governance arrangements in ICU. We observed a monthly risk meeting at which a wide range of issues were covered including new clinical guidance, clinical audit, incident and safety thermometer results, and staff recruitment issues. Minutes of the meetings were available to staff in the unit. We saw that items on the anaesthetic directorate risk register were discussed. For example nursing vacancies and staff levels were in the risk register from September 2013 and this had been updated to note the high levels of maternity leave through 2014-15.
- Audit information from intensive care was collated to submit for national benchmarking ICNARC data with all other critical care units. Additional local audits were being undertaken such as relatives' satisfaction questionnaire results, audits of ventilator care and infection prevention activity. An audit of delirium scores had just commenced at the time of our visit which was aimed at identifying early indications of psychological effects of critical care and monitoring the effects of sedation. We saw that results of audits were discussed at monthly risk meetings where relevant action points were agreed by senior clinicians.

## Leadership of service

- There was good local leadership in the intensive care service.
- We saw that medical, nursing and business managers worked together effectively at clinical and managerial level.

# Critical care

- Staff had clear responsibilities and ownership for managing aspects of the service such as day to day staffing or education and supervision of staff.

## Culture within the service

- Staff said they felt able to approach senior staff with any issues or concerns about the service or care of patients. They said that there was positive response from managers to raising issues. This view was also stated by therapy staff visiting the unit to provide care for patients.
- We found staff were supported well in the department. Nursing staff were in teams with clear supervision and training arrangements. Medical staff said they were well supported by a cohesive consultant team in the ICU.

## Public and staff engagement







- Satisfaction questionnaires were used to gather views from relatives and patients, these were available to visitors in the ICU waiting area and provided as patients were discharged from the unit. Patients gave very positive feedback about the care they experienced in the intensive care unit.
- Feedback collated from the follow up appointments included a view from some patients that they found it difficult to communicate their needs when intubated, with a tracheostomy or with the effects of sedation. This has led the staff to try different methods and tools to promote improved communication and understanding of patient needs.

- There was good engagement of staff in the intensive care unit, staff were included in ward meetings and there was open discussion of issues at all ward rounds and handovers. Information about the unit and key communications about service changes or safety messages were displayed in the staff rest room.

## Innovation, improvement and sustainability

- There was specialist equipment available for patients to have echocardiograms performed in the bed in ICU. The scans were also stored in the digital imaging system to enable specialist cardiology reporting. Medical staff were provided with education sessions and training in the ICU for this echo scanning. This meant less disruption and was safer for patients than would be usual as they would not require a transfer to a scan department. Echocardiography was used as the main monitoring tool of cardiac output and fluid status for intensive care patients. Point of contact echocardiography for these patients is a highly innovative and valuable service
- There was a clinical library outreach service with librarians spending time in clinical areas and joining multidisciplinary meetings. We saw that the librarian attended the risk meeting and was able to provide support and resources for clinical staff to access research based practice information.

# Maternity and gynaecology

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

## Information about the service

Annually, over 6,000 babies were born in the maternity unit at the Royal Derby Hospital. The maternity unit provided care for women with high and low risk pregnancies and was comprised of a birth centre, labour ward, ante and postnatal ward, antenatal clinic with day care and assessment facilities, 2 assessment couches and a foetal medicine centre. The labour ward had a high dependency unit for women who were at higher risk of complications.

The gynaecology service offered inpatient, day care and assessment unit facilities. They cared for women that had gynaecological related problems and for women that have early pregnancy issues, such as fertility or miscarriage. A team of gynaecologists specialised in specific problems and were supported by clinical nurse specialists, general nurses and healthcare assistants.

The labour ward provided care to women before, during and after giving birth. There were 12 single bed en suite labour rooms, a pool room and one bereavement suite. A four bed area provided care to women who were having their labours induced and a four bed high dependency unit for those women that needed extra care after the birth. Services included an antenatal clinic, including specialist/ medical services, ultrasound, foetal maternal medicine unit, pregnancy day care and pregnancy assessment unit. Specialist services were available. For example, diabetic care, drug and alcohol liaison and mental health.

Community midwifery was part of Royal Derby Hospital's maternity services. Working in partnership with GPs, health visitors, family nurses, children's centres and lifestyle

services, they promoted good health during pregnancy and early days following a baby's birth. Five teams of community midwives provided care in GP surgeries, health centres and during home visits including antenatal care, parent education classes, home births and postnatal care.

We inspected the Royal Derby Hospital gynaecology and maternity unit over three days. The team included an inspector, two specialist advisers and an expert by experience. We visited all wards and departments relevant to the service. We spoke with 23 patients, 28 members of staff, plus 18 community maternity staff who attended a focus group. We met and spoke with nine medical staff and four relatives.



# Maternity and gynaecology

## Summary of findings

The named midwife model was in place and women told us they had a named midwife. This process then proceeded to one to one care being offered by midwives on labour ward; however midwives told us that it was currently less likely to happen due to the demand on the ward.

We identified one set of records with important 'birth event details' absent. This was highlighted to the team and the event was retrospectively written in to the notes to support a safeguarding situation. We met with the safeguarding midwife to discuss an incident. We were told that the trust does not have a bruising policy; the non-accidental injury policy was followed.

The birth centre promoted a 'home from home' experience for patients who wished to have the comforts of a home birth with the added reassurance of being in a hospital. The fertility unit was open seven days a week. They aimed to achieve a pregnancy for as many couples as possible.

Community staff reported being concerned that at times their safety was compromised when lone working. They felt uneasy about walking in to some situations. Currently they did not carry security alarms or have any system whereby their whereabouts were logged.

## Are maternity and gynaecology services safe?

Good



Community staff reported being concerned that, at times, their safety was compromised when lone working. They felt uneasy about walking into some situations. Currently, they did not carry security alarms or have any system whereby their whereabouts were logged.

We identified one set of records with important 'birth event details' absent. This was highlighted to the team and the event was retrospectively written into the notes to support a safeguarding situation. We met with the safeguarding midwife to discuss an incident. We were told that the trust does not have a bruising policy, so the non-accidental injury policy was followed.

The planned and actual staffing levels were displayed at the entrance to each ward. We saw that the staffing on maternity wards did not always adhere to this. However, they were supported by staff from areas that were less busy. At times, this situation caused the service to be fragile and at risk of being under staffed.

There was no evidence of risk for perinatal mortality between April 2012 and July 2014. There had been 20 medication incidents reported between June 2014 and September 2014. Minor omissions, delays and unclear dosage were listed as the main reasons.

### Incidents

- An independent review of the maternity services at Royal Derby Hospital was commissioned by the chief nurse and director of quality for NHS Southern Derbyshire Clinical Commissioning Group (SDCCG). The report was published in April 2014. The purpose of the review was to investigate two whistleblowing letters and issues highlighted through serious incident (SI) reports. Issues raised related to staffing levels, treatment of staff, the lack of preceptorship for newly qualified staff and lack of obstetric consultant cover on the labour ward.
- As a result of the review, the trust have taken appropriate action with the development of a full action plan, monthly review meetings organised, audits commenced with some actions completed and draft papers written.

# Maternity and gynaecology

- Escalation of risk was identified through a Datix incident reporting system. The manager and the SoM (supervisor of midwives) on call were contacted if a serious incident occurred.
- Each reported incident was reviewed by the senior midwives. They met the matron weekly to discuss any issues and a fortnightly multi-professional meeting was held to discuss incidents in their areas.
- Following an incident investigation, a root cause analysis (RCA) report was developed. Incident review meetings (IRM) were held, minuted and attended by senior management team.
- Nineteen serious incidents had been reported since April 2014. These were monitored and the action plan reviewed with each manager. Three incidents related to maternal unplanned admission to intensive care.
- The intra-partum tool kit was in place. This had been developed by the National Patient Safety Agency to improve safety within maternity by providing guidance and resources to support improvement in monitoring and investigating incidents.
- There was no evidence of risk for perinatal mortality between April 2012 and July 2014. In 2013/2014 there were 23 deaths recorded and 16 recorded since April 2014.

## Safety Thermometer

- The maternity services told us they monitored their clinical outcomes through a maternity dashboard. We noted that not all data was collected effectively as identified during a 2014 independent review. A new format was being created by the head of midwifery to be presented at the December clinical improvement group. The maternity dashboard should monitor four categories including clinical activity, workforce, clinical outcomes and risk incidents, complaints and patient satisfaction surveys.
- The nationally recommended maternity clinical outcomes were measured in line with Royal College of Obstetricians and Gynaecologists guidelines (2008). Data showed that there were 11 attempted instrumental deliveries, which, for the safety of the baby and the women involved, resulted in emergency caesarean section between January and November 2014.

## Cleanliness, infection control and hygiene

- Compliance with the trust infection control policies and procedures was evidenced in the maternity and

gynaecology audit data from August 2013 to September 2014. Ninety percent and above was recorded for the year to date results in aseptic non-touch technique, cross infection audit, hand hygiene audit, isolation room audit, urinary catheters and peripheral cannula, against a target of 95%.

- All areas of the department were seen to be clean and well maintained.
- Staff were seen using hand sanitising gel and protective clothing. The 'bare below the elbows' policy for all staff was adhered to.
- We looked at the birthing pools and found them to be well maintained. Staff we spoke with knew the pool was cleaned, but were unsure of how. A variety of methods was described to us. The cleaning schedule was identified and placed in the rooms for future use.

## Environment and equipment

- The most senior qualified member of staff on duty had the responsibility to ensure that all resuscitation equipment was checked as per policy. We saw omissions in the documentation which demonstrated the resuscitation equipment had not been checked as per the policy.
- We discussed the procedure to evacuate a mother from the pool with the staff in the case of an emergency. The need to use a slide sheet was discussed. However we noted there was not one available in the room. This was rectified immediately and subsequently an evacuation trolley was been put in place, located adjacent to the birthing pool room.

## Medicines

- There were 20 medication incidents reported between June 2014 and September 2014. Minor omissions, delays and unclear dosage were listed as the main reasons. Staff involved had completed competency tests and the incidents were discussed at the ward meetings.
- We saw that VTE scores were recorded and monitored. Prophylactic treatment was prescribed and administered.
- We saw that medication was stored in locked cupboards within in clinical rooms.

## Records

- We saw that records were kept secure and away from public view. Records were maintained in a neat order.

# Maternity and gynaecology

- We identified one set of records with valuable birth event details absent. This was highlighted and written in retrospect to support a safeguarding situation.
- On the maternity unit we saw the individual maternity records were being reviewed as part of the women's care and the red books were introduced for each new born.

## Safeguarding

- Ward staff were aware of the trust's safeguarding policy and how to report a procedure.
- We met with the safeguarding midwife to discuss a recent incident that had not been reported. The incident was being reviewed by the senior staff. Unreported bruising had been identified on a baby and the notes did not clearly state the possible cause. We were told that the trust did not have a bruising policy, so the non-accidental injury policy was followed.
- The safeguarding team met twice a week to review patients and babies on the maternity ward. This was attended by the drugs and alcohol midwife, the mental health midwife, safeguarding midwife, plus the ward team. The community midwives had quarterly supervision to discuss their concerns and they could speak with any of the safeguarding leads if they wanted to raise any concerns.
- Community staff were concerned that, at times, their safety was compromised when lone working. They felt uneasy about walking into some situations. At the time of the inspection, they did not carry alarms, or have any system in place to enable their whereabouts to be logged.

## Mandatory training

- Each member of staff was responsible for attending their annual mandatory resuscitation training, as identified by their directorate.
- Overall, completion of mandatory training was high. Safeguarding was recorded at 95%, infection control at 89%, health and safety at 99% and patient handling at 92%.
- A cardiotocography (CTG) machine was used by midwives on the delivery suite to measure contractions and baby's heart rate over a period of time. CTG training compliance for 2014/2015 was recorded as 95.91%.

- All staff undertook annual newborn life support training as part of the midwifery training day. Advanced newborn life support training was only undertaken by senior midwives every four years.

## Assessing and responding to patient risk

- The maternity unit had introduced a maternity unit phone (MUP) for 'on call' purposes, which was held on a rotational basis by one of the senior midwifery managers (band 7) from 8am to 4pm onwards. The purpose of this was to make a senior member of staff available when the wards were busy and staff required additional support or guidance. This role did not include the senior clinical midwife coordinator in charge of the labour ward.
- Women that had problems in pregnancy were admitted for short periods of time to be reviewed regularly by the obstetric staff.

## The postnatal ward staff used the modified early obstetric warning score (MEOWS) to monitor new-born babies.

- The senior midwives on duty provided a cardiotocography (CTG) review known as 'fresh eyes' and assisted as the second midwife when delivery support was needed.
- The theatre staff followed the WHO surgical safety checklist, a 'five step' set of safety checks initiated at safety critical time points within the patients' care pathway to ensure their safety. This was audited at trust level in March 2014 and a score of 88% was achieved.

## Midwifery staffing

- The planned and actual staffing levels were displayed at the entrance to each ward. We saw that the staffing on maternity wards was not always as planned. However, they were supported by staff from areas which were less busy.
- The use of the Intrapartum Birthrate Plus Acuity Tool assessed the acuity of women against the workforce on a daily basis. At times, the acuity of the women exceeded the staffing levels.
- At the time of the inspection, there were 16 active supervisors of midwives (SoMs), giving a ratio of SoMs to midwives of 1:17. There were three student SoMs in training. Once trained, the ratio would reduce further. The SoM supported midwives in an advisory role.

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- The midwife-to-birth ratio was currently 1:28 (one midwife to 28 births). This had increased as a result of the additional funding from the trust management executive. With the increase in staffing, 12 midwives should be on each shift on the labour ward, which included midwifery staffing for both the consultant-led high risk care and the Derby Birth Centre. The high risk area planned for 13 midwifery staff on each shift and the Derby Birth Centre planned levels were three midwives, or 13 midwifery staff per shift in total. When not required, the birthing centre staff supported the labour ward.
- Staff vacancies were nil in maternity, 4.3% on the labour ward and 8% in gynaecology theatre. Substantive staff covered vacant shifts. The maternity unit did not use agency midwives. Their own midwifery contracted staff and bank staff covered any absence or leave. The maternity unit sickness rates were in line with the trust sickness rates.
- The named midwife model was in place and women we spoke with told us they had a named midwife. This process then proceeded to one-to-one care being offered by midwives on the labour ward. However, midwives told us that it was less likely to happen, due to the demand on the ward.
- Midwives in the community felt they could maintain the role of the named midwife. However, this was becoming more difficult as their caseloads got bigger.
- The area of the labour ward for high risk patients was set up to have two senior clinical midwives (band 7) on each shift with one identified coordinator in charge. They were included in the numbers for the whole ward, but oversaw care during breaks. The senior clinical midwife coordinator was supernumerary where possible. There were two senior clinical (band 7) midwives available on the labour ward each shift, including night duty and at weekends.
- Staff on the maternity unit currently had the choice of working traditional 7.5 hour shifts, or 12 hour shifts.

## Medical staffing

- There were 48 whole-time equivalent medical staff, including nine gynaecologists, six obstetricians and five obstetricians and gynaecologists.
- There was appropriate consultant obstetric cover on the labour ward, which, on average, was composed of 73 resident hours cover per week at the time of the inspection.

- Consultants were rostered for a 'hot week' working Monday to Friday, 9am to 5pm. This was a rolling weekly rota (1:6) and all their other clinical activity was not scheduled. The consultants stayed on the labour ward every evening (Monday to Friday) until 10pm and attended at weekends for eight hours of 'resident cover', usually 9am to 1pm both days.
- Handovers were carried out three times during each day and once in the evening. We observed that the formal 9am handover included a sit down handover, which involved discussing inpatients and overnight deliveries.
- The maternity service had approved safe staffing levels for obstetric anaesthetists and their assistants, which were in line with Royal College of Obstetricians and Gynaecologists (RCOG) Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour recommendations.
- At any time, two registrars covered the care on the gynaecology ward and labour ward. We were told that delays were experienced when discharges on the gynaecology ward were taking place and either of the registrars were required on the labour ward for review of patients and discharges.

## Major incident awareness and training

- Staff were aware of the major incident policy and senior staff knew of the business continuity plans.

## Are maternity and gynaecology services effective?

Good



Policies were based on NICE/RCOG guidelines. Local audit activity was displayed on the ward dashboard.

Patients we spoke with felt that their pain and analgesia administration had been well managed. We observed staff asking patients about their pain and the effectiveness of their analgesia. The trust promoted breastfeeding and the important health benefits now known to exist for both the mother and child from breastfeeding.

We saw good examples of multidisciplinary team working in the community and the hospital. Staff told us they had support from health visitors, GPs and social services. There was no evidence of risk for maternal and neonatal

# Maternity and gynaecology

readmissions between April 2012 and July 2014. This showed that safe and appropriate discharges were arranged and women had had appropriate support in the community.

## Evidence-based care and treatment

- Policies were based on NICE/RCOG guidelines.
- Care was provided in line with RCOG guidelines (including Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour).
- Local maternity audit activity was displayed on the ward dashboard. Privacy and dignity was measured at 100%, controlled drugs at 100% and VTE at 91%.
- The maternity service used a combination of National Institute for Health and Care Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists (RCOG) guidelines to determine the treatment and care provided.
- We saw that guidelines were in date with the review date was recorded. This meant that staff were assured that they were following current national guidelines. Policies and procedures were located on the intranet. Staff were able to access them easily.

## Pain relief

- We observed staff asking patients about their pain and the effectiveness of their analgesia. Patients we spoke with felt that their pain and analgesia administration had been well managed.
- On the maternity ward, we saw that a variety of pain relief methods were available, including transcutaneous electrical nerve stimulation (TENS) machines and ENTONOX®.

## Nutrition and hydration

- The trust promoted breastfeeding and the important health benefits now known to exist from breastfeeding for both the mother and her child. Their policy aimed to ensure that the health benefits of breastfeeding and the potential health risks of artificial feeding were discussed with all women to assist them to make an informed choice about how they would feed their baby. It was mandatory that the staff adhered to this policy. Any deviation from the policy had to be justified and recorded in both the mother's and baby's notes.
- In November 2014 breastfeeding initiation within 48 hours of birth was 78.9%. The trust target was set at 75%.

## Patient outcomes

- There were 5,959 births in 2013; 98.4% were single birth and 1.6% were multiple births. There were 1,582 births in quarter one of 2014.
- There were 48 unexpected admissions to NICU between April and November 2014.
- Maternal readmission rates for October 2014 was 3.3%. 134 maternal readmissions were recorded since April 2014, with a rate of 3.9% overall.
- The perinatal audit meeting minutes from November 2014 reported that there had been 534 births during October 2014. Other than these, 53.5% had been normal deliveries, 10.7% elective caesarean deliveries and 15.7% emergency caesarean deliveries. There was no evidence of risk for emergency or elective caesarean sections or maternity-related infections.

## Competent staff

- The practice development midwives were responsible for the induction programmes for newly appointed staff (not newly qualified) and were responsible for the maternity support worker (MSW) apprenticeship scheme at NVQ level 3 and the preceptorship programme.
- All newly qualified midwives undertook a 16 month preceptorship package, which was amended and re-introduced in October 2013. They completed four months in four different areas including community. The practice development midwife met with the preceptorship midwives on a designated study day every four months.
- Mentorship was linked with preceptorship and staff had an appraisal at the end of their first 12 months.
- Data provided by the trust showed that all staff had an appraisal in 2013/2014. As at August 2014, 85.7% of staff were recorded as having had an appraisal. Managers assured us that appraisal rates had been improved and were 100% at the time of the inspection. Staff we spoke with had all received their appraisals.
- An extensive programme of education and training was provided by the continuing professional development department. They provided opportunities for midwives to learn, develop and deliver safe and effective care.
- The Midwives had access to a supervisor of midwives (SoM) 24 hours a day seven days a week. The role of the SoM was formally recognised as part of the leadership



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structure of any maternity unit. The SoM was a source of professional advice on all midwifery matters and was accountable to the local supervising authority midwifery officer (LSAMO) for all supervisory activities.

- All staff completed a half day trust induction on their first day of employment with the trust. They were given an induction orientation form which was completed within their first week and stored in their personal files. Preceptorship midwives local induction was completed by the professional development team. When completed the line managers informed the learning hub team who updated the staff training passports. We were told that historically completion of the local induction was excellent and all staff reported being orientated to the area well. However, submission of the paperwork and completion of the e-form had been poor and in December 2014 all managers were reminded of their responsibility to complete this.
- Specialist midwives included infant feeding, bereavement, antenatal screening and neonatal screening, mental health support, drug and alcohol, diabetes, ultrasound scanning and counselling.

## Multidisciplinary working

- We saw good examples of multi-disciplinary team working in the community and the hospital. Staff told us they had support from health visitors, GP's and social services.
- The maternity unit had two designated physiotherapists and two assistants to support mothers with their mobility post caesarean section. They also received antenatal and post natal referrals, supported the gynaecology ward and the outpatients service.
- We observed staff and medical handovers where patient care was discussed and discharges planned.
- Communication with the community maternity team was efficient, and between GPs and midwives was well organised. The gynaecology wards and departments ensured that patients' discharge arrangements were appropriate.

## Seven-day services

- As well as the consultant on call from 10pm until 9am, there was one senior registrar and one junior registrar (one covered gynaecology and one covered the labour ward) and one senior house officer (SHO) on call every night and at weekends.

- Access to medical support was available seven days a week.
- The lead anaesthetic consultant for obstetrics was available during the day with on-call cover from 9pm to 9am.

## Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- Verbal consent was received from mothers before midwives carried out any tests on their babies.

## Are maternity and gynaecology services caring?

Good



Women who attended the maternity unit at Royal Derby Hospital felt they received good care. The women we spoke with told us staff were very caring and respectful. They felt information had been explained to them about their care and treatment and they were supported emotionally.

## Compassionate care

- Patients we spoke with told us that the staff were very caring and considerate. They had been spoken to with respect and their privacy protected.
- We heard examples of staff giving patients time to talk and allaying their fears.
- Maternity services were added to the NHS Friends and Family Test in October 2013. Currently, three methods were used to capture the NHS Friends and Family Test data: 'Your Views Matter' cards, text messaging via an electronic portal, which was introduced in March 2014.
- The September 2014 NHS Friends and Family Test achieved the following results:
- How likely are you to recommend the antenatal service to friends and family if they needed similar care or treatment? – 86 out of 100 was scored.
- How likely are you to recommend our labour ward/ birthing unit to friends and family if they needed similar care or treatment? – 76 out of 100 was scored.
- How likely are you to recommend our postnatal community service to friends and family if they needed similar care or treatment? – 81 out of 100 was scored.
- The CQC maternity survey of December 2013 surveyed 433 women who gave birth in February 2013. A total of



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220 women returned a completed questionnaire, giving a response rate of 51% compared with the national response rate of 46%. It showed that all measures were similar to the England national average.

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

- Patients told us that they felt well informed and were able to ask staff if they were not sure about something.
- On the post natal ward we observed a DVD played for new parents that explained about taking their new baby home and the after care. Parents we spoke with told us they found the DVD useful.

## Emotional support

- The maternity department offered a bereavement service which had been recognised by the RCM. The lead midwife had been nominated for Royal College of Midwives (RCM) award 2015, National Maternity Support Foundation (NMSF) award for bereavement care, improving the environment that was known to be an important key to effective bereavement care.
- The foetal maternal medicine unit offered specialist care to women who have complex pregnancies. The doctors, supported by specially trained midwives, offered special tests, counselling and advice to women who may have to make difficult decisions about their pregnancies.
- Midwives told us they observed women for anxiety and depression levels. They completed a mental health screening form when necessary and they were able to refer women to the mental health team, as necessary.
- Local independent counselling services were available. Information was displayed on ward notice boards.

## Are maternity and gynaecology services responsive?

Good



We found that 98% of eligible women at any gestation received a conclusive screening test result.

The birth centre promoted a 'home from home' experience for patients who wished to have the comforts of a home birth with the added reassurance of being in a hospital. The fertility unit was open seven days a week. They aimed to achieve a pregnancy for as many couples as possible.

Translation services were available and information was available in over 90 languages. The trust learning disability nurse lead arranged and monitored inpatients requiring support. Mothers requiring mental health support were risk assessed, referred and monitored as necessary.

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

- The trust collected data for the antenatal screening audit (sickle cell and thalassaemia) from April 2012 to March 2013. The data showed that, of 6,284 live births, 98% were screened. Nine 'at-risk' women/couples were counselled by an accredited trained professional. 94% of women completed an anomaly scan and 93 were amniocentesis tested.
- Ninety-eight percent of eligible women at any gestation received a conclusive screening test result. Transcutaneous Bilirubinometer (TCB) testing, a non-invasive test on the surface of the skin was carried out by the community midwives. As TCB was not accurate above a threshold level of 250 mmol (milimoles – a unit of measurement to express amounts of a chemical substance)/L of bilirubin, a total serum bilirubin blood test (TSB) was required for babies whose TCB was above this threshold level.
- The 'jaundiced baby' policy had been developed collaboratively with the trust's paediatricians and the neonatologists. Based on NICE guidance, the neonatologists adhered to the guidelines and requested that babies in the community who were seen to be jaundiced were to be reviewed in the hospital. At times this process had led to babies being brought to the emergency department. The trust was auditing the process.

## Access and flow

- The gynaecology assessment unit (GAU) provided rapid assessment and diagnostic services for all emergency patients and incorporated an early pregnancy assessment service. The gynaecology assessment unit was open from 9am to 4.30pm, seven days a week. Referrals were made by GPs, midwives, the emergency department and other community services.
- Incident forms had been submitted due to the high bed usage on the gynaecological ward for surgical outliers. During the inspection, nine outliers were present on the 21 bed unit. The medical and surgical bed managers were responsible for patient movement.

# Maternity and gynaecology

- We were told that, at times, the operating lists started without an inpatient bed available for the patient. This then caused pressure on the ward staff to ensure that patients were safely discharged to allow the postoperative patients onto the ward.
- Discharge planning was arranged on admission. Patients we spoke with on all the wards were aware of when they were due to go home. Discharge information was issued to patients with advice and guidance notes.
- There was an established maternity triage process and plans were in place to extend the assessment unit hours to 24 hours, seven days a week. This
- This assessment process would offer assurance and advice, allowing women to return home to increase the amount of home births.
- Bed occupancy for maternity services during the first quarter of 2014/2015 was 68.4%. This was above the England average of 57.3%. However, for the second quarter bed occupancy was 52.8%, the England average for the same period was of 59.9%.
- The maternity unit had temporarily suspended its service twice in the previous 12 months because of capacity issues. On one occasion this was due to the lack of capacity in the neonatal unit; the other occasion was due to lack of capacity on the labour ward.
- The urogynaecology department offered specialised care to women of all ages. There were three urogynaecological consultants and a specialist nurse who were highly trained to offer an individualised, patient-focused service from referral to discharge.
- Translation services were arranged when necessary and information was available in over 90 languages.
- The trust learning disability nurse lead met patients requiring additional support, which was arranged and monitored while the subject was an inpatient.
- Mothers and women requiring mental health support were risk assessed, referred and monitored as necessary. A number of midwives had chosen to specialise in a specific area of practice. Many of the midwives worked with specialists to provide a link with community maternity services. Having undertaken additional training, they gave additional advice and support to midwives and parents in areas such as diabetes, drugs and alcohol, antenatal and newborn screenings, twins and multiple births, bereavement support, infant feeding and child protection.

## Learning from complaints and concerns

### Meeting people's individual needs

- The birth centre promoted a 'home from home' experience for patients who wished to have the comforts of a home birth with the added reassurance of being in a hospital. They offered a birthing pool, home furnishings, specialist equipment, bean bags, mattresses, birthing balls, aromatherapy and sensory rooms to promote the comfort of women in labour. All rooms had sensory lighting and calming music.
- The community midwives offered an 'on-call' home birth service to support mothers that had planned a home birth, or required advice.
- The fertility unit was open seven days a week. They aimed to achieve a pregnancy for as many couples as possible. They offered support to unsuccessful couples going through to the next stage of IVF, adoption or to those who were coming to terms with childlessness.
- There were 18 complaints logged since April 2014. Thirty-eight percent were recorded as medical care provided and 22% were recorded as relating to staff 'attitude'. The complaint themes were shared with staff on their mandatory training days and by the SoMs when they met for their annual appraisal. Complaints were reviewed and discussed at the department meetings.
- The processes at RDH for receiving feedback from women were the NHS Friends and Family Test questionnaire, complaints, incident reviews, CQC maternity surveys and Local Supervising Authority Midwives (LSA) audits.
- The maternity service had an approved system for improving care and learning lessons relating to newborn life support that was implemented.
- The Patient Advice and Liaison Service offered help, support and advice to patients, relatives or carers, about any issues relating to Royal Derby Hospital.

# Maternity and gynaecology

## Are maternity and gynaecology services well-led?

Good



The trust's vision was 'Taking Pride in Caring'. The staff were familiar with the vision to enable people to maintain the maximum possible level of independence, choice and control, while supporting people to express their needs.

There was an active maternity services liaison committee (MSLC) and the maternity service was the only service in the UK to have maintained UNICEF WHO Baby Friendly Initiative accreditation scheme consistently since 1998. Their breastfeeding policy demonstrated their commitment to helping women get all the help, support and information they needed both before and after the birth of their baby.

### Vision and strategy for this service

- We saw that CARE principles of compassion, a positive attitude, respect and equality are at the very heart of care at Derby Hospitals. Staff told us how they met the individual needs of their patients in a compassionate and professional way. We were told that the managers promoted a positive workplace for the staff to deliver good quality care.

### Governance, risk management and quality measurement

- Regular reports on the maternity services were discussed at a number of maternity unit meetings, including the maternity governance committee and the divisional management board. The head of midwifery (HoM), QIL and matrons represented the maternity services at trust meetings, where incidents, complaints, quality and the maternity dashboard were discussed.
- The clinical governance facilitator role included risk, clinical governance facilitator quality and quality assurance, governance and safety and improvements. Weekly risk review meetings were led by the maternity risk manager. The consultant lead for risk and the senior midwives, who managed the clinical areas, also attended.
- In June 2012, the maternity service at Derby Hospitals NHS Foundation Trust achieved compliance with level 2 requirements of the Clinical Negligence Scheme for

Trusts (CNST) Maternity Clinical Risk Management Standards 2012/2013, scoring 47 out of 50. There were three areas of non-compliance and some areas of good and innovative practice were noted during the assessment. The trust is due for reassessment in June 2015.

- Midwives told us they were invited to the monthly perinatal mortality meetings where case review discussions took place by multidisciplinary teams. They considered any changes to practice, which may improve outcomes for patients.
- The trust had raised a risk issue relating to changes in the notification of birth services when it ceased to operate from 31 December 2014. The transfer of data to register a baby with an NHS number at birth would no longer be automatically generated and the IT system in place could not action this process. The unique number will be manually transferred to the current maternity system to complete the birth notification process. The risk of data input errors and potential delays in treatment/screening programmes had been noted.

### Leadership of service

- We heard that the new leadership team were working in partnership for the good of the directorate. We were told they listened and acted upon staff requests when there was evidence that it would improve the service.
- Staff we spoke with were aware of who the senior management were including the chief executive. Some members of the executive team had visited the directorate wards.
- Community maternity services staff told us that directorate and senior management were less visible within community services compared to the inpatient hospital services.

### Culture within the service

- The trust promoted a positive safety culture and encourages incident reporting, placing the trust in the top quartile of acute hospitals reporting to the National Reporting and Learning System (NRLS).
- The trust had linked with the 'Sign up to Safety' pledge to reduce harm to patients.

### Public and staff engagement







# Maternity and gynaecology

- The maternity services held open forums every four to six months for all staff to attend. They were invited to set the agenda, with topics they wished to discuss with the HoM and their management team.
- There was an active maternity services liaison committee (MSLC), which met bimonthly. The chairperson is a member of the National Childbirth Trust (NCT). We met and spoke with the chairperson. MSLCs are a forum for maternity service users, providers and commissioners of maternity services to come together to design services that meet the needs of local women, parents and families.
- The maternity service was the only service in the UK to have maintained the UNICEF WHO Baby Friendly Initiative accreditation scheme consistently since 1998. Their breastfeeding policy demonstrated their commitment to helping women get all the help, support and information they needed both before and after the birth of their baby.
- A community midwife became the North of England regional winner of the JOHNSON'S Baby Mums' Midwife of the Year Award for putting her mums first and providing excellent care. They were nominated by a grateful mum for being a **"talented, calm, considerate and assertive midwife"** before and after the birth of her baby.

## Innovation, improvement and sustainability

- The trust had been nominated and shortlisted for the Royal College of Midwives awards 2015 for 'bereavement care' for improving the environment; an important key to effective bereavement care.

# Services for children and young people

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

## Information about the service

Services for children and young people are provided by the paediatrics business unit which is part of the division for integrated care at the trust.

The children's hospital is part of the Royal Derby Hospital main site but has its own entrance and reception area. The purpose built unit was opened in 1996 and many aspects of the design were developed with input from the local community to create a child-focused facility.

There are three main ward areas: Dolphin, Puffin and Sunflower, an outpatient department with six clinical areas, a neonatal intensive care unit (NICU) and a children's emergency department (the children's emergency department was inspected as part of our review of urgent and emergency services). There was also a child clinical psychology service, a child development centre and a specialist nursing outreach service known as the KITE (Kids In Their Environment) team.

There are 45 beds spread across the three wards and currently 20 cots in the NICU (13 special care and seven critical care) with plans to add more in January 2015. The NICU is part of the Trent Perinatal Network.

39,000 children per year visited outpatients. Clinics included paediatric medicine, surgery, orthopaedics, dermatology, ophthalmology, oral, maxillofacial and ENT. There was also an audiology department, orthotic services, paediatric physiotherapy and a dietetics service.

During our inspection we visited all of these areas and spoke to 32 staff, 12 parents and looked at 10 records.

## Summary of findings

Staff on the children's wards and the neonatal unit worked hard to provide safe care. There were arrangements in place to monitor incidents, and staff were clear on their responsibilities. Staffing levels were appropriate at the time of our visit although we were aware there were pressure points in some areas.

Children were treated according to national guidance. We observed many examples of compassion and kindness shown by staff across all the departments and ward areas.

Services were planned and delivered to take into account local need. The capacity of the neonatal unit was stretched at times but there were plans in place to introduce more cots in early 2015. Services for children and young people were well-led. There were clear governance arrangements in place.

# Services for children and young people

## Are services for children and young people safe?

Good



Staff on the children's wards and the neonatal unit worked hard to provide safe care.

There had been no never events or serious untoward incidents reported since January 2013. There were arrangements in place to monitor incidents, and staff were clear on their responsibilities relating to this. Procedures were in place to learn lessons from incidents, and staff were aware of trends associated with incidents.

Children's inpatient and outpatient areas were clean and tidy, and there was sufficient, appropriate equipment available for staff to deliver safe care.

Staffing levels were appropriate at the time of our visit although we were aware there were pressure points in some areas.

Junior doctors told us there was only one registrar on duty for five different children's areas across the hospital from 11pm to 8am. Staff reported that this sometimes led to delays in children being reviewed.

### Incidents

- The service had systems in place to ensure that incidents were reported and investigated appropriately. Reports provided by the trust showed that a total of 191 patient safety incidents had been reported between 27 July and 2 December 2014. The service held monthly safety and risk meetings which were attended by a representative of each service area. The minutes of these meetings showed that a full record of every reported incident was circulated as a standing agenda item and discussed at the meeting. Where incidents had been reported a full investigation had been carried out and steps were taken to ensure lessons are learnt. Action plans were monitored and tracked to completion at the safety and risk meetings.
- Staff told us they understood their responsibilities to report incidents and knew how to raise concerns. Staff confirmed that they received feedback on incidents that

took place in other areas of the service as well as their own. We also saw evidence of this on staff noticeboards. Staff and managers were proud to describe themselves as high reporters of incidents.

- There had been no Never Events reported and no serious untoward incidents reported to the Strategic Executive Information System (STEIS) by the service since January 2013.
- The service held monthly paediatric mortality and morbidity meetings where cases from the previous month were presented by a clinician. We reviewed two sets of minutes and saw that discussion points and learning points were recorded, along with any actions.

### Cleanliness, infection control and hygiene

- All the areas we visited were clean, we saw housekeeping staff cleaning on the wards and in the departments throughout our visit.
- Hand washing facilities and hand sanitising gel were readily available and we observed staff adhering to the trust's policy on 'bare below the elbows' policy.
- The importance of visitors cleaning their hands was well publicised and we observed parents and other visitors using hand gel and washing their hands.
- Monthly infection control audits were undertaken. For the year to date Dolphin and Puffin wards were fully compliant with all the standards. Sunflower ward and the NICU had not achieved compliance in one area each. An action plan was in place to address this shortfall.
- There had been no cases of MRSA or C. difficile reported for the service as of the date of the inspection for the year 2014/2015.
- Infection control was a standing agenda item on the monthly risk and safety meetings. Matters discussed included training compliance, feedback on audits and updates on service developments.

### Environment and equipment

- The environment was purpose built, and designed with children in mind. The modern building provided a safe environment for children and families which was effective for cleaning and maintenance.
- Entrances to all children's ward areas were secure, with access by a swipe card for staff, or entry granted by a member of staff via an intercom system.



# Services for children and young people

- All staff reported adequate access to the relevant equipment and no concerns with maintenance. We reviewed a number of items on the wards and in the NICU and saw they had been recently inspected. All areas had safe spacious storage areas
- The ward areas and out patients had an ample supply of appropriate toys that could be cleaned safely.
- Age appropriate resuscitation equipment was available and there was evidence it was checked regularly. We identified one resuscitation equipment trolley with out of date stock which was quickly addressed when brought to the staff's attention.

## Medicines

- A paediatric pharmacist attended the children's ward and neonatal unit daily, reviewing prescriptions and making recommendations.
- Medicines were safely stored. All the drug store cupboards were locked and controlled medicines were stored in separate locked cupboards. Where medicines needed to be kept in refrigerators, the temperature was checked daily.
- We observed that, on Sunflower ward, the two nurses administering medicines wore a tabard indicating they should not be disturbed. This was done to promote safe administration of medicine and reduce the chance of medicines errors.
- The service had a dedicated pharmacist who worked across all the ward and department areas. The pharmacy team provided a Centralised Intravenous Additive Service (CIVAS) service where IV drugs were made up in pharmacy and delivered to the wards, making medicine administration safer and freeing up nursing time.
- All medication errors were reported as incidents, investigated and reviewed. All of these incidents were reviewed at the monthly risk and safety meetings.
- Minutes of the last meeting showed that during the period 13 October to 2 December 2014, there were 13 medication incidents, all were classed as low risk, but were fully investigated and reviewed.

## Records

- Records were kept confidential on the wards in trolleys by the nurses' station.
- We looked at ten sets of notes on the wards and in the NICU and found them to be accurate and legible. Information was easy to find.

- Documentation for admitting patients and assessing risk was child-focused.
- In the NICU, we observed one mother's midwifery record on the unit, while she was still an inpatient on another ward. This created a potential risk to safety if the mother's notes were not with her.
- The paediatric business unit had moved to e-prescribing in the two months prior to the inspection. We identified that there were occasions when a patient would have a paper prescription sheet as well an electronic one. It was not clear how staff would know if there was or was not a paper prescription when looking at the electronic system.

## Safeguarding

- Safeguarding policies and procedures were in place.
- Staff we spoke with understood their safeguarding responsibilities and knew what to do if they had concerns. One hundred percent of staff had completed standard safeguarding training. Eighty-five percent of staff had completed enhanced safeguarding training, against a target of 80%.
- The trust employed 1.8 whole-time equivalent (WTE) children's safeguarding liaison nurses who worked with wards and departments, raising awareness and offering support, advice and resources where necessary. Each liaison nurse also managed complex cases and worked between other health and social care organisations.

## Mandatory training

- Data supplied by the trust showed that most staff were up to date with their training. Ninety-three percent of staff had completed mandatory training and 98% of staff had completed statutory training.
- Staff we spoke with confirmed that they were up to date with training, or had dates to attend scheduled.
- All the wards areas displayed information about training for staff. Where wards/units had not achieved full attendance at training, action plans were in place.
- The trust had recently introduced a system of training passports in the months prior to the inspection. This enabled managers and staff to access information on training so they could see when updates were needed.

## Assessing and responding to patient risk

# Services for children and young people

- A paediatric early warning score (PEWS) system was in place on the children's ward, based on the NHS institute for innovation and improvement PEWS system. This tool supported early identification of children at risk of deterioration.
- PEWS assessments had been completed in the four care pathways we reviewed.
- Staff were able to explain the process of reviewing the scores, and what to do when there were changes in the score, which indicated that a child's health was deteriorating.

## Nursing staffing

- There were 148 WTE nursing staff working in paediatric services. The safe staffing dashboard was displayed in the children's ward areas and on the neonatal unit. This showed details of the required levels of staffing, and actual levels present on each shift. Staffing levels were adequate, as was the required skill mix on the day of our inspection. We saw that staffing levels conformed to the Royal College of Nursing (RCN) guidance.
- During our inspection, staff were visible, despite the ward areas being busy, particularly on Puffin ward. Staff and managers told us that it was sometimes challenging to meet peaks in activity, particularly when multiple theatres were running.
- Where there were shortfalls in staff due to sickness or annual leave, staff across the ward areas would be flexible and cover shifts. It was the responsibility of the pager holder on each shift to find cover. Where this was not possible, bank staff who were familiar with the wards areas were used. As a last resort, agency staff would be used, but managers told us this would be very rare. Procedures were in place to request agency staff if needed.
- At the time of our inspection, the neonatal unit had 3.57 WTE vacancies and a sickness rate of 6.1%. These issues put pressure on the nursing staff in the unit. The director of nursing told us that staffing in the neonatal unit was a concern. We met one member of staff who had been in post two months. They had not previously worked in paediatrics and had not completed the relevant NICU qualifications. The unit sister explained that, because of difficulties recruiting staff with the relevant qualifications, they had moved towards bringing in staff and supporting them to gain the right qualifications once they were in post.

- On the neonatal ward the trust employed five advanced neonatal nurse practitioners (ANNPs). These are very experienced nurses with additional training which enabled them to work autonomously to the equivalent of up to a registrar level doctor.
- The trust employed 15 play specialists (11 WTE), most of whom worked part-time. Play specialists were seen as an integral part of the ward and department teams, offering a service from 7am to 7pm, seven days per week.
- Nursing staff had a twice daily handover, this was classed as protected time and staff were not to be disturbed. In outpatients, staff had a full briefing session before the start of clinic every day.

## Medical staffing

- There were 49.9 WTE medical staff working in paediatric services. This included 22 consultants, directly working in paediatric services. A further 22 consultants visited from other children's hospitals to provide services. The proportion of consultants was in line with the England average. There were no middle career grade doctors, but twice as many junior grade doctors than the England average.
- The trust also had a number of visiting consultants from other trusts providing specialist care and treatment in areas such as rheumatology, cardiology, plastic surgery and urology.
- Junior doctors reported that they had good training and support from their senior consultants.
- The doctors on the neonatal unit had effective links with the postnatal ward, and they had oversight of babies on that ward.
- Junior doctors told us there was only one registrar on duty for two children's wards, the HDU area, children's emergency department and the neonatal unit from 11pm to 8am. A consultant was on call but not on site. Staff reported that this could sometimes lead to delays in response, if the registrar was busy. Staff said the consultant on call would usually come in for the neonatal unit, but there can still be delays.
- There were two handover sessions per day for the medical teams. We observed that the consultant was present at both handovers we attended.

## Major incident awareness and training

# Services for children and young people

- Staff were aware of the major incident and business continuity policy, and understood their roles and responsibilities within a major incident.
- On the neonatal unit the staff regularly carried out scenario training for different medical emergencies. These were run by the ANNPs and the full multi-disciplinary team were involved.

## Are services for children and young people effective?

Good



Children were treated according to national guidance. The services had an annual clinical audit programme to monitor that guidelines were being adhered to, although meetings to review progress were not minuted. The service audited their performance against national guidelines, and generally performed well.

Children were cared for by a multidisciplinary team of skilled and dedicated staff. Staff felt supported and had access to training. Consultant presence and support was provided over seven days.

### Evidence-based care and treatment

- Children were treated according to national guidance, including guidance from the National Institute for Health and Care Excellence (NICE), and the Royal College of Paediatrics and Child Health (RCPCH).
- Appropriate care pathways were in use and were in keeping with the relevant National Institute for Health and Care Excellence (NICE) clinical or nursing guidance.
- Policies, procedures and guidelines were available to all staff via the trust intranet. Staff we spoke to knew how to access them when necessary, and we quickly found a random selection of policies on the system.
- Most policies were up to date. Although, some policies in the neonatal unit had not been updated as planned they were still current. We noted one guidance note which was dated 2003, relating to antibodies which cause haemolytic disease of the new born. This was an appendix to the trust's transfusion policy.

- The service was involved in a range of local and national audits. Progress was monitored through regular clinical audit meeting, which were well attended by doctors for all grades, but minutes were not taken of these meetings so it was difficult to track progress.
- The children's audiology service undertook a wide range of audits and peer review to develop their service and were able to describe a number of changes they had made to the service as a result of the audits, such as developing outreach clinics.

### Pain relief

- Pain was assessed and managed appropriately. We observed a number of age-specific tools in use and the appropriate national guidance was followed. Appropriate equipment was available including for patient-controlled analgesia (PCA).
- The lead anaesthetist for children was involved with the children's pain service and pain strategy.
- The play specialist team were available in each ward and department, and provided valuable distraction therapy for children undergoing different procedures.
- Parents confirmed that the staff worked hard to make sure that their children were not in pain.

### Nutrition and hydration

- The ward areas had a protected mealtime's policy, which meant that children and young people could eat without being disturbed, except for parents and siblings. We saw that this was observed by staff on the ward.
- Children's likes and dislikes regarding food were identified and recorded as part of the nursing assessment on admission.
- Children and young people were able to choose what they wanted to eat from a menu. There was a two week rolling menu which was displayed on the notice boards in the wards for children and their families to view.
- There was support from paediatric dieticians, who were available for specialist advice and support, with special diets and feeds. The staff were also aware of how to order specialist menu choices, such as halal food or gluten-free meals.
- The records we reviewed during our inspection showed that any fluid or dietary intake was monitored and recorded where necessary.

### Patient outcomes

# Services for children and young people

- The service took part in all the national clinical audits that they were eligible for.
- The trust took part in the National Neonatal Audit programme (NNAP). The annual report showed that, for the period of January to December 2013, the trust achieved one out of five of the key standards. The trust achieved the standard that all (100%) of babies of less than 28 weeks gestation have their temperature taken within one hour of delivery. The other standards related to: mothers of premature babies receiving antenatal steroids (77% against a target of 85%); babies receiving retinopathy of prematurity screening (90% against a target of 100%); babies receiving mother's milk when discharged from a neonatal unit (58% against a target of 59%) and a documented consultation with parents within 24 hours of admission to NICU (84% against a target of 100%).
- The trust took part in the National Paediatric Diabetes Audit (NPDA), published in 2013. The audit showed that the trust had a better proportion of children with a Glycated Haemoglobin (HbA1c) level below 7.5% compared to the England average. NICE guidance states that an HbA1c level below 7.5% indicates that diabetes is well managed.
- Hospital episode statistics (HES) data for 2013/2014 showed that the trust had a higher than average readmission rate for children under the age of one year old after surgery. This was 2.9% compared to 0.9% for England. We asked the trust to explain this. The trust reviewed the data and identified that the data focused on 27 cases where the baby had been coded as 'admitted' due to birth within the hospital and staying with their mother on the postnatal ward. None of these babies received care on the neonatal unit or on the postnatal ward. Of the 27 only two were actually readmitted following treatment.
- Readmission rates for children and young people with asthma or diabetes were better than the England average for July 2013 to June 2014. However, for epilepsy, while the readmission for children under the age of one year was better than the England average, for children over one year it was worse.

## Competent staff

- Data we saw on the wards and in the departments showed that most staff had had an appraisal in the last 12 months. Staff we spoke with during the inspection

confirmed this. All the staff we spoke to told us how well supported they felt by their ward teams, managers, and the senior nursing and managerial staff within the business unit.

- During our inspection, we met a new staff nurse in the neonatal unit. They were completing a 4 week supernumerary induction period and the unit sister told us that, in conjunction with the nurse, they would plan further development to ensure they achieved the relevant neonatal qualifications.
- We saw that staff had the right qualifications and had access to further development. For example, the trust employed five ANNPs who were highly skilled members of staff, making a positive contribution. Although these staff did tell us they would like to extend their skills set further, there was limited funding for this.
- On Puffin ward, staff were routinely required to care for young people who required a Child and Adolescent Mental Health Services (CAMHS) assessment. Staff were not trained to care for patients with these needs and staff told us they found it challenging to cope with at times. The sister on the ward told us she was aware of plans for staff to receive training, but this had not yet materialised.
- The medical staff we spoke to all confirmed that they had received an appropriate induction when they started work and had an appraisal planned to identify training needs. They told us that they received good training opportunities, and access to clinical supervision. One junior doctor told us they felt it was better than most places they had worked at.

## Multidisciplinary working

- There was strong evidence of multi-disciplinary team working in all departments, within and outside the children's business unit. We also saw evidence of external engagement with other agencies such as social services and networking with other children's services to share learning and specialist expertise.
- The clinical psychology team worked closely with medical and nursing staff for children with complex needs throughout the referral, discharge and transition processes.
- The KITE team were pivotal in linking hospital and community services. The team were expanding to meet the demands of patients with more complex needs and those transitioning to adult services.

# Services for children and young people

- The neonatal unit had a family nurse liaison service, where babies discharged from the unit were followed in the community. The team worked closely with community based services such as health visitors and GPs to ensure care was transferred effectively.

## Seven-day services

- There were consultant ward rounds seven days a week on the wards, and they were available out of hours through on-call arrangements.
- Dolphin and Puffin wards operated a 24-hour service. Sunflower ward was used mostly for day case surgery and would close at weekends. Sunflower would stay open in the early evening if a children required an overnight stay following their surgery and then would be transferred to Puffin ward, which was directly next to Sunflower. On occasions, there were weekend day surgery lists, in which case the ward would open.
- There was access to imaging services and pharmacy support out of hours, and at weekends, through an on-call system.
- Play specialists provided a seven day a week service between the hours of 7am and 7pm.
- Physiotherapy services were available seven days a week, with a physiotherapist visiting the children's ward twice a day. Out-of-hours support was available through an on-call system.
- Outpatient clinics were held Monday to Friday.
- Child and Adolescent Mental Health Services (CAMHS) were provided by another NHS trust. This service was only available 9am to 5pm on week days. There was no specialist input available to a child in need of CAMHS outside these hours.

## Consent

- Parents were involved in giving consent for examinations, as were children when they were at an age to have a level of understanding.
- We observed how staff talked and explained procedures to a child in a way they could understand without getting frightened.

## Are services for children and young people caring?

Good



Services for children and young people at the hospital were caring. We observed many examples of compassion and kindness shown by staff across all the departments and ward areas. Parents spoke highly of the care given and told us they felt involved in their child's care.

We saw that staff spent time with children, young people and their parents to make sure they understood their care and treatment and were supported throughout their time in hospital whether as an inpatient or an outpatient.

## Compassionate Care

- An inpatient survey conducted in August 2014 showed that 90% of patients were positive about their overall impressions of the service.
- Throughout our inspection, we saw staff interacting positively and in a considerate manner with children, young people and their families in all of the areas we visited.
- We saw that staff were respectful of individual needs and took these into account. For example, on Puffin ward, teenagers had their own area and were given individual rooms with bathroom facilities. This also ensured that privacy was maintained.
- Parents we spoke to told us they had been treated with respect and compassion by the staff and praised their attitude and approach.

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

- During our inspection, we observed staff communicating with patients and parents so that they understood their care and treatment. Parents told us they felt well informed and could ask any questions of the staff if they wanted to.
- Two parents we spoke to said there had been issues when they had not felt informed, but when it was brought to the staff's attention the situation was remedied. We spoke with one parent on a ward who was particularly unhappy with communication, but we saw the nurse in charge take steps to talk with the parent and reassure them that actions were being taken.



# Services for children and young people

- Staff told us that the hospital had access to interpreters if required, but we did not observe them being used during our inspection.
- We saw that there was good support for children with hearing or sight problems and this was extended to the community.
- Many parents we spoke with told us they felt involved in planning and making decisions about the care and treatment of their child. For example, one parent told us the surgeon explained to their young child about the planned procedure in a way that allayed any anxieties they had.

## Emotional support

- It was evident from our discussions with staff that they were aware of the need for emotional support to help children and families cope with their care and treatment. This was confirmed through our discussions with parents and relatives.
- Staff and managers were aware of how anxiety can impact the welfare of the child and made provision, where needed, to manage this. For example, the orthotic service made sure that one child had their appointments with the same orthoptist to minimise their anxiety levels.
- The hospital's clinical psychology department was able to provide emotional support although waiting lists for this service were lengthy. Clinical psychology was also included as part of the KITE team services.
- The trust's play specialist team worked alongside nursing and medical staff to provide support to children and young people, using techniques such as diversion therapy. Parents spoke highly of this service and how they had helped with treatment.

## Are services for children and young people responsive?

Good



Children and young people's needs were met. Services were planned and delivered to take into account local need. Managers were part of a number of

commissioner-led meetings and there was evidence that changes had been made to services as a result. The capacity of the neonatal unit was stretched but there were plans in place to introduce more cots in early 2015.

Complaints were managed in line with trust policy and lessons were learnt. However, there was limited information for families regarding how to make a complaint and it was not available in other languages or formats.

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

- The business unit was involved with a number of service planning meeting with commissioners to develop the services. These included CAMHS pathway development meetings, the disabled children's commissioning group and the Derbyshire children's trust board. These external meetings ensured that services were planned and delivered to meet the needs of the local population.
- Services were flexible and developed with the needs of local children in mind. For example, the KITE team which provided outreach services to children with complex needs was developing and expanding its team in response to local demand.
- The trust had recently secured additional funding from the commissioners for more clinical psychologists. This was in direct response to increasing demand.
- Service Level Agreements (SLAs) were in place with other hospitals for specialist services where the trust did not directly employ consultants such as cardiology, rheumatology and urology.

## Access and flow

- On the day of our inspection the neonatal unit had 19 of the 20 cots in use and was on "red" status. This meant that they could only take emergency admissions. Between April and October 2014 the unit has been on "red" status 108 times and on "black" status 95 times, out of a total of 312 shifts during that period. Black status is when the unit was closed to external admissions but internal access remained open for emergency admissions as required. Any planned deliveries of babies would be discussed between the neonatologist and obstetrician to decide if it was safe for delivery at the trust or whether the mother and baby should be transferred to another hospital.
- Cot capacity in the NICU was on the business unit risk register. The unit was currently running at an occupancy



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level of 87% for level 1 and level 2 critical care cots and at 98% for special care cots. The optimum occupancy level is 80%. This meant the unit was challenged with regard to maintaining the availability of emergency cots and providing the optimum safe nursing levels.

- The occupancy rate on the paediatric wards was 54.5%. Staff told us they rarely had to cancel operations due to bed shortages.
- In out-patients we saw that clinics were busy but provided a flexible service. Parents we spoke to said that there had been no problems with appointments on the whole and that they were seen reasonably promptly in the clinic. One parent told us that they had been able to co-ordinate multiple appointments for their child to minimise waiting times.
- The current waiting time for an out-patients paediatric appointment was 12 weeks. For most specialties such as cardiology, the waiting times were around eight weeks.
- There were long waiting times for children's clinical psychology services. The waiting time for a general appointment was 11 months at the time of inspection. Waiting times for specialist assessments were even longer. For example, for an autism assessment, some children were waiting 16 months. The trust had recognised this as an issue and it had been raised on the business unit risk register. Funding had recently been secured from commissioners for three additional clinical psychologists and the trust was in the process of making these appointments. The associate clinical director told us that these staff were being specifically employed to address these long waiting lists.
- Staff in the out-patients department told us that capacity could be an issue at times as there were not always enough rooms to accommodate all the clinics.
- The KITE team had developed a flexible service to improve access for adolescents. For example, clinics were held in the evening and transition services for diabetes and managed flexibly.
- Children could be admitted via the children's emergency department which was adjacent to but separate from the main emergency department. The children's emergency department had recently developed a short stay observation unit which was based at the back on the department. This was used, usually for a few hours and allowed patients to be monitored for a short while, negating the need to admit the child to the ward.

## Meeting people's individual needs

- Each ward and department catered for the needs of children. This included ensuring that there was enough space by each bed or neonatal cot for a parent to visit comfortably and there was accommodation made available for parents to stay with children overnight.
- There were sufficient play areas on the wards and an outside play space was available. Staff felt that the service was flexible enough to meet the needs of all children admitted to the wards, regardless of complex physical needs. We observed good facilities for children with disabilities and parents of disabled children said they felt their needs were met.
- Staff we talked with were aware of how to access a telephone translation service or face-to-face translator.
- A play team was able to provide qualified play specialists and play assistants to children's services, seven days a week, from 7am to 7pm. The play team were informed of all planned admissions, and were involved in multidisciplinary ward rounds, as necessary.
- The children's outpatient clinics were spacious, light and bright, and had a good range of play equipment for all ages which was kept to a good standard.
- All the areas we visited provided a good range of written information about the treatment and care for a range of conditions. However, we noted that there was very limited information in languages other than English.

## Learning from complaints and concerns

- Posters informing children and families regarding complaints and concerns were on display in the ward and department areas. Leaflets detailing how to make a complaint were not freely available. Staff told us they held them elsewhere and would give out a leaflet if requested. We only saw posters and leaflets in English, so information for people where English was not their first language was not provided.
- Staff and managers told us that they preferred to deal with family's concerns directly, rather than directing them to make a formal complaint. We observed a situation where a relative was unhappy with the care provided to their child and the nurse in charge of the ward took steps to remedy the situation immediately.
- Since January 2014, the trust had received seven formal complaints about services for children and young people. Most of these complaints related to waiting times.

# Services for children and young people

- We saw that complaints and concerns were discussed at the monthly risk meetings. Staff were aware of complaints management practices, and received feedback to improve practice.

## Are services for children and young people well-led?

Good



Services for children and young people were well-led. Ward level leadership was found to be effective and well managed.

There were clear governance arrangements in place that monitored the outcome of audits, complaints, incidents and lessons learnt throughout the service.

There were a number of innovative practices in the service which had led to improvements in services for children both in hospital and in the community.

### Vision and strategy for this service

- The management team for services for children and young people had a clear vision for the service. Safety and quality were clearly the top priorities for the management team. There were clear plans in place to develop and enhance the service to meet demand for planned services and further integration with community services to improve transitional care.
- The management team were aware of how they fitted into the wider management model for the trust and felt they were acknowledged and valued.
- The majority of staff understood the vision and strategy for developing the services, and said that they felt informed. Staff were also aware of the trust's vision and values and were able to articulate these.

### Governance, risk management and quality measurement

- There was a clear governance framework and responsibilities were clear. Monthly safety and risk management meetings were held with representatives from all of the key service areas. There were a number of standing agenda items including reported incidents, complaints and infection control. Staff from each area fed back to staff following these meetings to ensure teams were informed of the key issues.

- These meetings fed into the wider divisional structure to ensure that trust-wide issues were picked up and any concerns from the paediatric group were reported.
- All areas were subject to a ward assurance process which was a composite score from a range of indicators. Paediatrics was currently achieving 97.9% against a target of 93%.
- A risk register was in place which described all of the key concerns for the business unit. There were 12 items currently on the register, most of the risks related to waiting times for different specialist services such as clinical psychology, cardiology and mental health services.

### Leadership of service

- We looked at copies of board papers, governance meetings, risk registers, quality monitoring systems, and incident reporting practices. These showed that there were management systems in place that enabled learning and improved performance, and were continuously reviewed where required.
- We saw that the business unit clinical leaders and managers encouraged co-operative, supportive relationships among staff and teams, and compassion towards patients. Leaders were visible and approachable and described themselves as a family
- Ward managers we spoke with also said that they felt supported by their senior management, and that if they raised any concerns about the service, they would be listened to.

### Culture within the service

- Staff told us that there was a positive culture within teams, and that staff supported each other well. We saw that staff worked well together in multidisciplinary teams to provide holistic care to children.
- The staff described an open culture, where they were encouraged to report incidents, concerns and complaints to their manager. Staff felt able to raise any concerns.

### Public and staff engagement

- The trust undertook an NHS Friends and Family Test staff survey in July 2014. The net promoter score was +21. This meant that more staff would promote the trust as a place to work than not. There was no national comparable data for this score. Although the senior

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managers were positive about the overall scores, they were concerned about some of the comments made on the survey and sent out a staff communication regarding dignity at work matters.

- We saw a number of examples as to how staff were kept informed by managers of service developments. Staff we spoke with said they felt engaged in services.
- Services used a variety of methods and tools to collect feedback from patients and parents regarding the care and treatment provided. For example, the KITE team had introduced iPads in the department as a device to collect feedback from children and the audiology team in outpatients had recently instituted an ongoing survey to proactively seek the views of children and families.
- The trust's 'Your views matter' feedback cards were available on the wards and in departments. We noted that these cards were not child-friendly and we saw no cards available in other languages or formats.

## **Innovation, improvement and sustainability**

- We saw a range of innovations which helped to provide a flexible and responsive service. For example, working with colleagues in the children's emergency department the service had recently developed a short stay observation unit, used usually for a few hours to allow patients to be monitored for a short while, negating the need to be admitted to the wards and so improving bed capacity and improving patient experience.
- The KITE (kids in their environment) team provided an innovative outreach support service to children with chronic conditions in their homes. The service had proved popular and they were expanding and developing the service as a result. This included employing a youth worker for the team.

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

## Information about the service

Derby Hospitals NHS Foundation Trust had a specialist palliative care 20 bed inpatient unit, the Nightingale Macmillan Unit (NMU). This was dedicated to providing end of life care to patients with a life-limiting illness. The NMU ran a 24-hour advice line for patients, carers and healthcare professionals. End of life care was also delivered, where required, by ward staff throughout the hospital.

The hospital palliative care team (HPCT) provided support and advice to staff across the hospital for those patients who had complex care needs and/or symptom management. Emotional support was available for family and friends of end of life patients.

There were a total of 898 inpatient deaths in the trust between April and August 2014.

We visited the following wards within Derby Hospitals NHS Foundation Trust: NMU, oncology ward 303, short stay unit ward 306, winter pressures ward 311, department of medicine for the elderly wards 405 and 406 and cardiology ward 408. We also visited bereavement services, the faith centre, the resuscitation department and the mortuary.

We spoke with over 50 members of staff including: nurses; doctors; therapists; chaplains; mortuary staff; and housekeepers. We spoke with 10 patients and two relatives. We observed interactions between patients and staff, considered the environment and looked at care records. We also reviewed the trust's end of life care performance data.

## Summary of findings

We found inconsistencies in the completion of 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms across the hospital, including mental capacity assessments.

Mental capacity assessments were not completed for 93% of patients deemed not to have capacity to make and communicate decisions about cardiopulmonary resuscitation.

End of life care followed national guidance and the trust participated in national audits. However, there were inconsistencies with the use of end of life care documentation across the trust.

The trust planned to implement a rapid discharge 'home to die' pathway in 2015. The fast track discharge pathway used was not effective.

Patients and relatives all spoke positively about end of life care. Staff were enthusiastic and passionate about the quality of care they provided.

# End of life care

## Are end of life care services safe?

Requires Improvement



End of life care services required improvement to be safe.

We found inconsistencies in the completion of DNA CPR forms across the hospital. Thirty-one out of 35 forms were not completed in line with trust policy. For example, forms were not always signed by appropriate grade doctors, or endorsed by the consultant responsible for the patient, forms did not always have discussions with patients about DNA CPR documents and the process for when the DNA CPR forms were submitted when a patient was discharged was not clear. This put patients at risk.

We found out-of-date single-use equipment.

Staff throughout the trust understood their responsibility to report incidents and we found evidence to support learning from incidents. Staff knew how to assess and respond to patient risks, including safeguarding.

### Incidents

- Within end of life care services there were two incidents reported in the Strategic Executive Information System (STEIS) between April 2013 and March 2014. One was categorised as a slip, trip or fall; and the other was a grade 3 pressure ulcer.
- We saw evidence of immediate action being taken by mortuary staff following incidents to ensure lessons were learnt. An example of this was where the mortuary manager implemented extra checks around post mortems following an incident where a post mortem was carried out on a deceased patient with **human immunodeficiency virus (HIV)**, where mortuary staff and the pathologist were not aware until afterwards.
- Staff reported incidents on the trust-wide electronic reporting system. This was available in all ward areas via the trust intranet home page. Staff we spoke with understood their responsibilities to raise concerns, to record safety incidents and near misses. Staff told us that generally they received feedback from concerns and incidents reported.

### Safety Thermometer

- NHS Safety Thermometer information was displayed on the Nightingale Macmillan Unit (NMU) for staff and

patients to see. On the 9 December 2014 it showed there had been no reported ward-acquired pressure ulcers for 222 days, no reported falls with harm for 595 days, no reported cases of MRSA for 982 days and no reported C. difficile incidents for 453 days.

### Cleanliness, infection control and hygiene

- Mortuary staff were able to explain the trust's infection prevention and control policy and procedure for the care of the cadaver. There were zipped cadaver bags, allocated fridges and a post mortem room available in the mortuary for deceased persons who had notifiable infections to prevent the spread of infection.
- Mortuary staff undertook daily physical body checks of the deceased to ensure spaces were clean and free from body fluid.

### Environment and equipment

- We found two open equipment store rooms in areas accessible to the public on NMU. This meant that equipment such as syringes and dressing packs were not stored safely and securely to prevent theft, damage or misuse.
- On NMU we found out-of-date equipment including three one-piece Guedel airways which expired in 2013 and a clear guard midi breathing filter which expired in 2010. We reported these to nursing staff, who disposed of the equipment. The housekeeper told us that they were responsible for checking the equipment but had misplaced the out-of-date items and instead of disposing of them had left them in the store room.
- NMU had daily equipment checklists for staff to complete, such as ensuring resuscitation equipment was fit for purpose and commodes were clean. There were weekly equipment checklists to ensure equipment such as oxygen, suction equipment and call bells, on the ward were fit for purpose. We saw checks had been carried out.
- Audits of trust cardiac arrest trolleys in August 2013 and January 2014 showed that there was improved compliance for the trolleys being checked in line with trust policy from 90% to 95%. However, compliance with trolleys containing the correct equipment had deteriorated from 98% to 88%; and trolleys holding the correct documentation had declined from 98% to 94%. Results were shared with the clinical areas and within the divisions. In July 2014 a further audit showed performance for correct documentation had increased

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to 98%, checking had increased to 97% and correct equipment had increased to 92%. The monitoring of cardiac arrest trolley compliance was to be reported on the monthly ward assurance audit.

- The concealment trolley (a trolley designed for the respectful movement of patient body from the ward to mortuary) cover was frayed. The mortuary manager told us that they had requested a new one as they felt this did not uphold the respect of the deceased but it had not been provided.
- The National Patient Safety Agency (NPSA) recommended during 2011 that all Graseby syringe drivers (a device for delivering medicines continuously under the skin) should be withdrawn by 2015. The Graseby syringe driver had been withdrawn from the hospital and the majority of nursing staff throughout the trust had been retrained to use the McKinley syringe driver.

## Medicines

- The National Care of the Dying Audit 2013/2014 showed that the trust was performing better than the England average for the clinical key performance indicator (KPI) 'medication prescribed prn (as needed) for the five key symptoms that may develop during the dying phase'.
- Pain assessment tools were used to assess patients' levels of pain. Nurses we spoke with were clear about how to assess for changes to a patient's condition and what medication would be required.
- The trust's end of life benchmarking tool audit 2014, used on 23 medical wards, showed that all staff felt that they would be able to administer medication as needed in a timely way.

## Records

- There were multiple patient notes used on NMU. For example, the medical notes were stored in the doctor's room, the nursing notes were stored in the nursing room, and the nursing assessment notes stored at the end of patient beds. The risk register recognised that there was a moderate risk of suboptimal care for patients, due to multiple teams gathering similar information independently of each other, leading to duplication and risk that critical information would be lost.
- Doctors told us that having different patient notes to the nurses' meant that notes were always accessible. They told us that having two daily doctor and nursing ward

handovers ensured that information was shared in a timely manner. One doctor commented: "The handovers are very detailed, they are the best I've ever done." We observed ward handover was discussed in a systematic way, with care plans considered and patient risks highlighted.

- In October 2014, the trust audited 50 DNA CPR forms to assess if they were completed correctly. The results showed some forms were not being completed in line with trust policy. For example, 44% of forms did not have any communication with relatives documented. Recommendations were made and a repeat audit has been planned. Following our inspection the trust told us the audit only looked at the DNA CPR forms and communication with relatives could have been in the medical records.
- We found inconsistencies in the completion of DNA CPR forms across the hospital. We sampled a total of 35 records of patients that had a DNA CPR order in place across NMU and five medical wards (303, 306, 311, 405 and 406). All forms had the reason for DNA CPR documented. However, 31 forms were not completed in line with trust policy.
- We found nine forms not endorsed by the consultant responsible for the patient, despite reviewing the patient since the order had been placed. We found two examples on ward 406, where the consultant had printed their name, but it was illegible. Therefore, the consultant endorsing the order could not be identified.
- We found that seven out of 14 forms on NMU did not have any patient details on the grey DNA CPR form copy. This meant that when the forms were separated there was a risk of patient details not being transferred onto the form.
- Twelve forms had no documentation to reflect that the DNA CPR had been discussed with the patient. Fifteen forms had no documentation to reflect that the DNA CPR had been discussed with the patients' relatives. Where F2s had signed the form they told us that they occasionally documented in the medical notes the discussion held with the patients' families regarding DNA CPR, but not always.
- Staff were confused about where the DNA CPR forms were submitted to when a patient was discharged. Some nurses and doctors reported that the original red form should go with the patient on being discharged, if the order was still in place. Whereas others told us the grey copy form followed the patient. The DNA CPR form



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had conflicting guidance. On the front it stated: "Return the red copy to resuscitation department for audit." On the reverse of the form it stated: "The original copy of the DNA CPR form should accompany the patient during transfer and a photocopy returned to the resuscitation department for audit." This put patients at risk because if a patient was discharged with an unacceptable form it could result in inappropriate resuscitation, as the form was valid for five days post discharge.

## Safeguarding

- The trust had a dedicated safeguarding team. The team supported trust staff to keep them informed on safeguarding issues and provide safeguarding training.
- Staff were knowledgeable regarding their role and responsibilities to safeguard vulnerable adults and children from abuse and understood what processes to follow. Safeguarding standard and/ awareness training was between 95% and 100% on NMU for additional clinical services staff, doctors and nurses.

## Mandatory training

- All nursing staff on NMU had received fall awareness training and 94% had received falls prevention training to ensure nurses had the skills to reduce the risk of patient falls. However, tissue viability training compliance was at 54% and recognised by the ward manager as an area for improvement.
- The NMU staff information board showed nursing staff compliance with training for November 2014. Patient handling and **aseptic non touch techniques** were above 90% compliance, with hand hygiene and infection control training both at 89% compliance.
- There was 79% compliance with resuscitation automatic external defibrillation training for nurses and 80% for doctors on NMU. This did not meet the trust target of 95% and could put patients at risk if staff did not know how to operate the defibrillation equipment.
- There was 68% compliance for hospital resuscitation and hospital life support for additional clinical services staff.

## Assessing and responding to patient risk

- There was a daily ward round on NMU, including weekends, to ensure deteriorating patients could be identified and escalated if required.

- NMU had a daily clinical assessment checklist for nurses to complete to ensure patient clinical assessments had been completed. For example ensuring the Malnutrition Universal Screening Tool (MUST) assessments were up to date.
- Risk assessments for patients for pressure ulcers and falls were being completed appropriately and reviewed at the required frequency to minimise patient risk.
- The end of life benchmarking tool audit 2014, used on 23 medical wards showed that staff on 22 wards were able to identify patients who were clinically unstable with limited reversibility. All ward staff were able to describe how they would recognise a patient in the last days and hours of life. We saw evidence to support that early warning scores were used to monitor patients and initiated calls to the cardiac arrest team when required.

## Nursing staffing

- The HPCT provided support, advice, training and care to patients and staff on a trust-wide basis. The team responded to all referrals from clinicians throughout the hospital for adult patients who had complex support and/or symptom management needs during end of life care. The team establishment was 7.2 whole time equivalent nurses. However, one post had not been advertised for recruitment for almost 12 months and staff told us this had created huge pressure on the rest of the team.
- NMU had a 5.5% registered nursing vacancy and 5.7% healthcare assistants and other support staff vacancies. NMU had a safe staffing board that displayed the planned and actual number of staff on duty. On one day of our inspection, NMU was a registered nurse short for both the early and late shifts. Some nurses told us that when the ward was fully staffed, staff would be redistributed to other trust wards that were beneath their own staffing levels. They told us that this happened approximately twice each month and increased pressure on the NMU staff.
- NMU average registered nursing staff turnover was 4.7% between April and August 2014. This had reduced since 2013, which meant that staff were staying longer on the unit.

## Medical staffing

- Medical staff were present on NMU from 8am until 6pm. There was an on-call consultant available out of hours to provide end of life advice for the trust.

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- There was one palliative medicine consultant who was a core member of the HPCT. There was an extended team of palliative care consultants who could provide cover.

## Major incident awareness and training

- The trust had a major incident plan. Staff we spoke with were familiar with their role within the major incident plan.
- Mortuary staff were familiar with their role in a major incident. They told us that they could access additional facilities in the event that the mortuary reached its capacity and we saw there were sufficient resources such as space and electricity, in a lockable outdoor courtyard area outside the mortuary vehicle entrance. The mortuary manager told us that mortuary capacity usually ranged from between 50% and 75%. Therefore, major incident plans had not yet required implementation.

## Are end of life care services effective?

Requires Improvement



We found mental capacity assessments were not completed for 93% of patients deemed not to have capacity to make and communicate decisions about cardiopulmonary resuscitation.

There were inconsistencies with the use of all end of life care documentation across the trust.

End of life care followed national guidance and relevant links to guidance and support was available on the trust intranet. The National Care of the Dying Audit 2013/2014 showed that the trust performed better than England average against clinical key performance indicators (KPIs) and achieved four out of the seven organisational KPIs.

Staff generally felt competent in providing end of life care and clinical supervision was available for all staff.

NMU and the palliative care team demonstrated strong multidisciplinary team working which linked with other trust services. Palliative care clinical nurse specialists provided a seven days service and NMU operated a 24 hours advice line for patients at home, their carers and health professionals.

## Evidence-based care and treatment

- End of life care services followed guidance by the National Institute for Health and Care Excellence (NICE) Quality Standards for End of Life Care, 2011, updated 2013. Standards were being met with the provision of a specialist palliative care team who provided seven day working and could be contacted in person or by telephone out of hours.
- The HPCT had taken action in response to the 2013 review of the Liverpool Care Pathway (LCP). Individual care plans for patients believed to be dying, were used to communicate care and treatment. This was in line with the recommendations published by the Leadership Alliance for the Care of Dying People (LACDP) (2014).
- However, care plans were inconsistently used despite a user guide being released to staff. An audit of the end of life care plans for 30 deceased patients in 2014 showed documentation focused on physical care needs such as hygiene and tissue viability with no documentation regarding spiritual and religious support for patients. The audit concluded that the evidence collected indicated that following the withdrawal of the LCP, nurses required further support in developing individualised care plans for patients in the last days and hours of life.
- End of life facilitators told us a repeat care plan audit was intended and actions would be developed to improve compliance were needed.
- The trust had implemented the AMBER care bundle, and appointed a facilitator, on 22 wards across the trust, to manage the care of patients at risk of dying within the following two months. The AMBER care bundle is an approach used in hospitals when clinicians are uncertain whether a patient may recover and are concerned that a patient may have a few months left to live
- The end of life care plans for deceased patients audit 2014 showed that nine out of 30 patients had the AMBER care bundle in place. Nurses we spoke with on medical wards told us that the AMBER care bundle was inconsistently used on wards. The HPCT recognised that sustainability with ward staff using the tool was a challenge and that they often revisited wards to remind staff to use the tool.
- The future plan was to roll the AMBER care bundle out across the surgical wards.
- The trust had a 'recognising dying' yellow documentation sheet to highlight patients likely to be dying and may be in the last hours or days of life. On the

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reverse of the sheet, there was guidance to encourage doctors to reflect upon why the patient was considered to be dying, what hospital services were involved in the patient's care, and communication with the patient and their family. The end of life care plans for deceased patients audit 2014 showed that only six out of 30 patients had the 'recognising dying' sheet in place.

- We found that bereavement services audited if medical records of deceased patients contained the 'recognising dying' documentation sheet. From the previous 65 records audited, five contained the documentation. This meant that the 'recognising dying' documentation sheet was not being used. When patients were transferred from another ward to NMU, there was a specialist palliative care NMU admission sheet stored in the medical notes that had essential handover information about the patient recorded.
- The trust had a 'following death' documentation sheet which encouraged staff to consider whether any precautions were required around infection control; religious, spiritual and cultural needs of the deceased; post mortems; and possible coroner cases. We found only two examples of this documentation being completed adequately.
- The HPCT was part of the **Derbyshire Alliance for End of Life Care, which had** produced an end of life toolkit for staff across the local area. The toolkit was available online and provided information about the end of life care plan, medication and care after death. Staff told us the information was useful when supporting patients at the end of their life.
- On the intranet, the 'Trust policy and procedures relating to the death of an adult patient' had a review date of February 2014 which had lapsed. All other related end of life policies and procedures we looked at were up to date.

## Pain relief

- Patients identified as requiring end of life care were prescribed anticipatory medicines. These 'when required' medicines were prescribed in advance to promptly manage any changes in patients' pain or symptoms.

## Nutrition and hydration

- Patients told us the hospital food was nice. In addition to three main meals each day, the NMU provided an afternoon snack round to help maximise patient

nutrition. Hot and cold snacks were available for patients outside of meal times on NMU. Patients were able to store their own food in the NMU patient-allocated fridge. Items were labelled with names and dates of opening to promote food safety standards.

- On NMU we found that most patients had a drink within their reach (12 out of 13 patients) which meant they could maintain hydration.
- Patients with special dietary requirements or who required assistance with eating were highlighted on the NMU kitchen board. We saw patients being assisted to eat.
- Information regarding nutrition and hydration in palliative care was displayed on a board in NMU for staff, patients and visitors to learn about optimising intake and preventing malnutrition.
- Recommendations for clinicians regarding artificial nutrition and hydration, and the legal and ethical guidelines for adult patients were available on the intranet. This included end of life care advice.

## Patient outcomes

- The National Care of the Dying Audit 2013/2014 showed that the trust performed better than England average against clinical key performance indicators (KPIs) such as multi-disciplinary recognition that the patient is dying, review of the patient's nutritional requirements and review of the care after death.
- The trust was achieving four out of the seven organisational KPIs, including trust board representation and planning for care of the dying. However, the trust failed to achieve KPIs such as access to specialist support for care in the last hours or days of life; and continuing education, training and audit.
- The trust participated in the National Cardiac Arrest Audit (NCAA) from April to September 2014. The trust collected data for 90 reported cardiac arrests in the hospital. The results largely mirrored the national average throughout the report. For example, there were similar findings for 'cardiac status at cardiac team arrival' and 'reason for resuscitation stopped'.
- Occupational therapy and physiotherapy did not have NMU patient outcome measures and, therefore, were unable to demonstrate patient outcomes as a result of their service.

## Competent staff

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- The professional development facilitator told us that new nurses on NMU completed trust induction, mandatory training and then were supernumerary for two weeks on NMU to enable them to shadow established staff. One new nurse told us that they had also completed competencies on the unit, including the administration of intravenous fluids and verification of death training.
- The NMU staff information board showed an 88% staff compliance with appraisal for November 2014.
- NMU nurses and the HPCT told us that they were regularly offered clinical supervision.
- We spoke with two new F2 doctors who told us that they had received an induction on the unit from the consultant and that all ward staff had helped them to become familiar with the systems and practices in place. They told us that they could access clinical supervision if they requested this.
- Nurses on medical wards told us that they felt competent to provide end of life care for patients and were aware they could refer to the HPCT. However, they did feel that there was a lack of end of life care training available for established staff.
- In the hospital palliative care multidisciplinary team annual report for April 2013/2014, the team declared it provided less teaching within the year, due to capacity issues. Yet it continued to deliver 'bite-size' teaching on some wards, end of life workshops and advanced communication skills training.
- Palliative care clinical nurses specialists all held, or were working towards, degree status.
- All members of the HPCT had completed advanced communication skills training.
- Mortuary staff provided annual training for porters about transferring the deceased, this included infection control and storage.
- We saw a business case for staff end of life care education for 2015/2016, based upon the LACDP (2014). The palliative care team intended to develop a competency-based education and training programme that enabled staff involved in end of life care to have the essential skills and knowledge required to deliver high quality care.
- There was succession planning in place for the mortuary service.
- NMU had a strong multidisciplinary team where all disciplines that we spoke with felt well respected and listened to by the team. The team included nurses, doctors, Allied Healthcare professionals, chaplains, complementary therapists and creative workers. We observed a multidisciplinary team meeting where each member of the team had the opportunity to speak and contribute to patients' treatment plans.
- The professional development facilitator told us that they had implemented a programme for community nurses to visit the hospital to understand the role of staff within the acute team and this had provided two-way learning about end of life care between the acute and community service. This meant that there was improved staff understanding of the trust's end of life care pathway.

## Seven-day services

- Palliative care clinical nurse specialists provided a seven days service, from 9am to 5pm.
- NMU operated a 24-hour advice line for patients at home, their carers and health professionals. The NMU nurses were responsible for the line, answering queries and signposting people as to how to obtain the most appropriate source to meet their needs.
- Physiotherapy and occupational therapy provided a weekday service for the MNU. On Saturdays, there were occupational therapists and physiotherapists available that provided treatment for urgent patients in the trust. Physiotherapy provided an out of hours on-call service for urgent patients in the trust. A physiotherapist told us that they would care for patients on the MNU out of hours for treatment, such as secretion management for respiratory comfort.
- Complementary therapy was available during weekdays and bank holidays.
- Mortuary staff were on call out of hours for urgent cases, such as tissue donation.
- Bereavement services were open Monday to Friday 8.30am to 4.30pm. Out of hours mortuary staff would note deaths and notify bereavement services upon their return.

## Access to information

- There was a whiteboard on each ward that staff could input symbols to identify patients on specific treatment pathways. For example, patients following both the 'AMBER care bundle' (an alert system to identify patients

## Multidisciplinary working

# End of life care

who were not responding to current treatment) and end of life care pathways, were allocated respective symbols. This meant that staff across the trust could identify how many patients there were on each pathway.

- On the trust intranet there were relevant links to guidance and support. For example, the **Derbyshire Alliance for End of Life Care tool kit and end of life literature reviews**.

## Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- During an NMU ward round we witnessed the consultant recognise that a patient with dementia had not yet received a mental capacity assessment and request this to be completed.
- We found that 14 out of the 35 DNA CPR forms we sampled indicated that patients did not have capacity to make and communicate decisions about cardio-pulmonary resuscitation. However, of these patients we found one mental capacity assessment completed. This meant that 93% of patients deemed to not have capacity had no mental capacity assessment completed, which was not line with trust policy, or the Mental Capacity Act 2005.
- We discussed mental capacity with three F2 doctors. None of them felt that not assessing capacity before completing a DNA CPR was of concern. One commented: "Mental capacity assessments would be good practice, but we don't usually."

## Are end of life care services caring?

Good



Compassionate end of life care was provided to patients by ward staff, particularly on NMU.

Patient and relatives we spoke with told us they felt involved with care and were treated with dignity and respect. This was mirrored in the trust feedback questionnaire.

The chaplaincy aimed to meet the religious and spiritual needs of patients and their family and friends.

## Compassionate care

- The trust offered a National Bereavement Survey 2011 (VOICES) questionnaire between April and November 2014 to all bereaved relatives with the exclusion of where the death had happened in the emergency department, those referred to the coroner and paediatric deaths. The results of the survey showed that the majority of respondents rated the staff as excellent in terms of communication, emotional support and, in particular, dignity and respect.
- Ninety-three per cent of respondents felt the personal wishes of the deceased were respected by staff. The majority of respondents felt that the religious, cultural and spiritual beliefs of the deceased were respected by staff.
- The National Care of the Dying Audit 2013/2014 showed that the trust achieved the organisation KPI of a clinical protocol promoting patient privacy, dignity and respect, up to and including after the death of a patient.
- One patient told us that: "Nothing is too much trouble," and, "Nurses go the extra mile." One relative commented: "I couldn't wish for [patient's name] to be in a better place."
- Mortuary staff were assigned to the family of the deceased to provide continuity of care.

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

- The results of the VOICES questionnaire (April to November 2014) showed that 91% of respondents felt that they were involved with decisions made about their loved ones.
- One patient told us that: "Doctors explain things to me" and "Ward staff have been excellent".

## Emotional support

- There were spiritual well-being care plans in some NMU patient notes that stressed the beliefs and needs of the patient. The National Care of the Dying Audit 2013/2014 showed that the trust performed better than the England average in terms of assessment of spiritual needs of the patient and their nominated relative or friend.
- Friends and family of the deceased were offered a bereavement appointment for emotional support. The



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results of the VOICES questionnaire (April to November 2014) showed that the majority of respondents felt they received the right amount of emotional support from staff.

- Half of the respondents to the VOICES questionnaire (April to November 2014) reported that they had been able to talk to a staff member about their feelings regarding the illness or death of their loved one. For the remaining respondents 41 out of 46 comments submitted reported that no information had been provided to access such a service.
- Relatives of deceased patients where organs had been donated could speak to the specialist nurse for organ donation for support.
- The chaplaincy had three full time and two part time chaplains, who provided a service seven days a week. One chaplain was part of the end of life steering group. The chaplain told us that they had good working relationships with other faiths to ensure the religious and spiritual needs of patients were met.
- There were regular religious services within the faith centre. If patients were unable to attend services, a chaplain or volunteers were able to visit patients at their bedsides to provide a faith service.
- The chaplain gave us examples of how they had supported staff members with peer or personal bereavements. For example, they provided a service for staff on a ward where a staff member had died.

## Are end of life care services responsive?

Requires Improvement



The trust did not have a rapid discharge home to die pathway in place, this was planned to implement in 2015. The fast track discharge pathway used was not effective.

Only 63% of patients seen by the HPCT had their preferred place of care identified, of these 74% achieved preferred place of care.

There was a specialist 20 bed palliative care unit in which staff aimed to improve patient quality of life by helping with physical symptoms, emotional and social concerns. The ward had excellent facilities to meet patients' individual needs.

We saw learning from complaints and concerns took place.

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

- The HPCT completed an annual preferred place of care audit. The results showed that 63% of patients had their preferred place of care identified. This had improved in comparison to 51% and 32% in 2012 and 2011, respectively. Of those patients seen by the HPCT 74% achieved their preferred place of care; 24% did not achieve their preferred place of care; and for the remaining 2% the outcome of preferred place of care was unknown. The number of patients achieving their preferred place of care had increased compared to 69% in 2012 and 63% in 2011. The HPCT planned to investigate the results.
- Members of the HPCT attended the **Derbyshire Alliance for End of Life Care** regional group and an end of life implementation meeting which aimed to enhance end of life care across the local area. For example new guidance, current care and innovative plans for the future across Derbyshire were discussed with the community and external bodies such as the Southern Derbyshire Clinical Commissioning Group, Derbyshire County Council and local hospices.
- The HPCT told us that they met regularly with the Southern Derbyshire Clinical Commissioning Group and worked together to plan end of life services.

## Meeting people's individual needs

- On NMU there was a day room with a television, books and games; free Wi-Fi; a courtyard garden; a spiritual room; and a smoking room for patients to use.
- Two complimentary therapists provided therapy for inpatients at either the patient's bedside or within the complimentary therapy room on NMU depending on the patients mobility.
- The complimentary therapists were passionate about providing quality treatment to patients to help them relax and would individualise treatments to ensure patients gained optimum benefit from the session. Treatments such as reflexology, aromatherapy and massages were available for patients to access.
- One patient told us that the treatment was 'brilliant' and 'relaxing'. One complimentary therapist told us that they would also offer treatments to patients' friends and family and ward staff if they felt it would be of benefit.
- A hairdresser visited NMU weekly and a chiroprapist visited every two weeks to provide services for patients.



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- There were facilities on NMU to enable patients' friends and family to stay overnight. The relative's room that had been dedicated for this purpose was being used as a patient room as part of the trusts winter pressure plan, however, two camp beds were available for settlement in patient rooms. There were bathroom facilities that friends and family could use.
  - NMU staff told us that visiting times were in place but that restrictions were regularly lifted which enabled family and friends to spend un-limited time with their loved one. Pets were also allowed to visit patients on the ward.
  - Nurses on medical wards told us, where possible, they would find a single room to care for patients at the end of life to protect their privacy and dignity.
  - On ward 406 we found the families of two deceased patients had been contacted in advance to alert them that the patients were in the last stages of life. The end of life care plan for deceased patients audit 2014 showed that 24 out of 30 families were prepared for the patients death. This meant that the families could be with their loved ones at the end of life.
  - The adult emergency department had a treatment room adjacent to the resuscitation area that could be used as a viewing room. It provided a private area where relatives and friends could be alone with the deceased before leaving the department. There were two doors to the room, which meant that relatives and friends could exit without going back to the resuscitation area.
  - Physiotherapists told us that if patients were suitable they could participate in the Tai Chi group or received hydrotherapy sessions, to help relieve pain and promote relaxation.
  - Friends and family of the deceased were offered information booklets 'A practical guide to what to do when someone has died' to guide them through the pathways of events post a death.
  - The chaplain told us they had facilities to provide emergency marriages and civil partnerships within the trust.
  - We did not see any patients who did not speak English however ward staff told us translation services were available throughout the hospital.
- established good links with clinical teams, such as respiratory and heart failure, to increase the teams knowledge and skills of end of life care and therefore patient HPCT referrals were often fewer.
- NMU had a dedicated nurse organising ward admissions and discharges for four days each week. This responsibility rotated weekly amongst the nurses. For the remaining three days ward nurses had to organise admissions and discharges within their standard nursing time which took nurses away from direct patient care.
  - We observed part of a NMU multi-disciplinary team meeting. Three out of nine patient cases we witnessed had planned discharge dates within the following week. However, six out of the nine patients had planned discharge dates for January 2015. One of these patients was on the fast track pathway. There was a lack of urgency to discharge patients home.
  - The HPCT audited 143 referrals in December 2014 to evaluate their response to referral time. The team responded to 91% of referrals within 24 hours, 98.5% within 48 hours and 100% within 72 hours. Response times had deteriorated since the last audit in May 2008 when 94% of patients were seen within 24 hours of referral. However, the majority of patients continued to receive HPCT contact within 24 hours of being referred, meeting the HPCT operational policy.
  - Occupational therapists and physiotherapists told us that they could respond to most NMU patient referrals within 24 hours and home visit request within 48 hours. However, although they collected data on paper regarding their referral to treatment times, the data was not analysed and therefore they could not establish an accurate referral response time for their services.
  - The trust had no formal rapid discharge home to die pathway in place. A rapid discharge pathway enables patients with a predicted life expectancy less than 24 hours, to be discharged within four hours.
  - A system was being developed to allocate a district nurse to a patient across Derby city and Derby Community Health Services using a single point of access to facilitate rapid discharge. We saw evidence that this development was in progress. The HPCT told us that they hoped to achieve it in 2015.
  - A fast track patient discharge process was in place for patients who deteriorated and could enter a terminal phase. Some nurses told us that if patients did not need additional help at home they could often be discharge

## Access and flow

- The HPCT received 1,433 referrals, with 935 deaths, between April 2013 to August 2014 of which 88% related to patients with cancer. The HPCT told us that they had

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within 24 hours. However, the majority of nurses on medical wards told us that discharge was often delayed due to the availability of the local authority to confirm care packages and that sometimes arranging a fast track discharge could take most of the day taking them away from patient care.

- Ward nurses and the HPCT told us that at weekends a manager's signature was required to obtain patient equipment for discharge. This could delay discharge.
- We looked at three patient notes on NMU that were on the fast track discharge pathway. One patient had been on the fast track discharge pathway for five days. A nurse told us the delay was because an ambulance visit was required at the patients' home first. Another patient had been on the pathway for seven days due to delays in continuing health care availability. The third patient had had their pathway started on another ward in the hospital the previous week but no discharge plans had been confirmed, as the patient was out of area. This meant that the fast track discharge process was not effective.
- NMU nurses and allied healthcare professionals told us that they did not know of any patients that had died in hospital but wanted to die at home. They told us that there were no issues with obtaining equipment for Derby patients but for patients living outside the area there could be delays. However, all staff reiterated that discharge was planned in advance to ensure that all equipment and care plans were in place before a patient was discharged. There was a discharge resource folder on NMU and nurses told us that the discharge liaison team were available in the day if they needed assistance with discharge.

## Learning from complaints and concerns

- In the NMU Inpatient Care leaflet there was information about how to share views regarding NMU and how to complain via the trusts patient advice and liaison service.
- NMU had received one formal complaint between September 2014 and October 2014, regarding medical students observing sensitive end of life conversations with a patient's family. We saw clear learning from this. For example, information was available on the NMU webpage about why medical students would wish to observe practice for their own development and if people would prefer this not to happen to inform staff.

- We saw informal complaints received by NMU were discussed at the monthly unit meeting. Compliments and complaints were also shared with staff via the ward staff information board.
- NMU had over 40 thank you cards on the ward from patients and their families and friends. These were either on display on the ward and in the nurses room. One card commented: "I cannot think of anywhere better than the Macmillan unit and its staff for its dedication to its patients".

## Are end of life care services well-led?

Requires Improvement



There was no strategic plan documented regarding the future vision of the end of care at the trust. Some team objectives were documented on the hospital specialist palliative care multi-disciplinary team work programme for 2013/2014. However, it was unclear when the information had last been updated.

All staff we spoke with were enthusiastic and passionate about the quality of end of life care provision. The HPCT were proactive in completing audits and benchmarking exercises to evaluate and improve care. They worked with the local health economy to enhance end of life care across the local area.

There were governance processes in place to monitor the quality of end of life care. However, when we reviewed the medical risk register not all risks associated with end of life care had been identified.

## Vision and strategy for this service

- The trust's vision and values were displayed throughout the hospital, on the intranet and they formed the basis of the staff development review and appraisal process. Staff we spoke with were aware of and committed to deliver the trust's visions, values and objectives.
- The HPCT could describe their vision and objectives for the future of trust end of life services, for example, the implementation of an electronic patient alert process. However, there was no formal plan or strategy documented about how the trust would achieve these

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objectives. The trust had chosen to follow the Derbyshire Alliance Strategy which was why they had not formulated their own strategic direction for end of life care.

## Governance, risk management and quality measurement

- The hospital specialist palliative care multi-disciplinary team had a work programme for 2013/2014. This outlined team tasks such as service development, audit and research. However, it was unclear within the programme when the information had last been updated.
- There was a bimonthly trust end of life steering group meeting. The group objectives were to implement five key enablers from the Transforming End of Life Care in Acute Hospitals programme, including the AMBER care bundle which had been implemented, and a rapid discharge home to die pathway which was under development.
- The chair of the end of life group was a member of the patient experience committee to help provide governance and accountability of patient and public feedback regarding end of life care.
- There were monthly ward assurance audits to highlight compliance with clinical risk assessments, for example pain and resuscitation status. However, when we reviewed the medical risk register there were no risks identified in relation to the absence of a rapid discharge home to die pathway or failure to have an ineffective fast track discharge pathway.

## Leadership of service

- The chief nurse represented end of life care at board level to ensure end of life care was highlighted at trust board level. In October 2014 the end of life team presented to the trust wide quality committee which is a sub committee of the trust board.
- The chaplain told us that they had access to senior management and had presented twice to the executive trust board. A non-executive director had met with the chaplaincy to provide support.
- NMU had a staff information board to keep staff updated with relevant KPIs and notices. For example for November 2014 the board displayed what the ward was doing well for instance, there had been a reduction in falls and an overall under spend on equipment. It also

presented what needed to improve on the ward, such as, the ward manager had highlighted a need to improve compliance with tissue viability training and appraisals.

## Culture within the service

- NMU staff told us that they were happy coming into work and they had a good team. All staff we spoke with including those working on NMU, in the bereavement office and in the mortuary, told us that they believed they delivered good care to patients at the end of life and after death.
- The HPCT were clearly dedicated to providing high-quality end of life care.
- Complementary therapists were very passionate about deliver quality care and one told us: "I have the best job".
- The nurse sickness levels for NMU were displayed on the ward staff information board. For November 2014 the sickness level was 8.4%. This was recorded as the highest figure for over a year. The rolling average sickness level was 3.8%, worse than the trust target of 3.2%.

## Public and staff engagement

- The adult emergency department wrote to families of patients who had died in the department two weeks after the death. They offered their condolences and extended the opportunity to speak with the bereavement care team, either by telephone or in person and also supply a feedback form.
- During 2013 the adult emergency department sent out 149 letters and received 28 contacts from relatives. During December each year the department completed an audit of bereavement care. We saw the summary of this audit from December 2013 with actions for improvement for 2014.
- The trusts staff impression of the friends and family test showed that for quarter two 2014/2015, 90% of staff would recommend the trust for care. This was an improvement on the quarter one 2014/2015 results by 2%.

## Innovation, improvement and sustainability


- The trust organised 'Pride of Derby' staff awards to recognise outstanding practice. The NMU team had won

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many of these awards. One award for the team stated: “Going the extra mile for patients and relatives every day”. Staff on the unit had also been individually recognised,

- The palliative care team had produced and developed a training DVD with examples of end of life discussions between patients, relatives and healthcare professionals, to emphasise the importance of good communication. They had created an associated facilitator's handbook to help the trainer use the resources effectively.
- The trust palliative care team had published a trust palliative medicine newsletter, designed to promote best practice, training and education opportunities. The first newsletter was issued in October 2014 with the second due in March 2015. Readers were asked for ideas of topics to be included, to ensure the newsletter targeted the concerns of the audience.
- The HPCT were proactive in completing audits and benchmarking exercises to evaluate the end of life care provided to patients, and the support given to their family and friends. This enabled them to plan improved care in the future.
- We saw evidence of the palliative care teams working with information technology to implement an email alert system where details of patients identified as being at the end of life on the palliative care electronic system could be flagged to the team. This would allow the HPCT to be notified of admission of palliative patients. It was hoped that this could be implemented in 2016 when information technology systems were being updated to make them more user friendly.
- The mortuary had two post mortem rooms. One was an isolations room, for deceased that needed to be kept separate, for instances such as infection control. Both rooms had viewing areas and teaching facilities such as cameras, where students, healthcare professionals and external personnel, such as the police, could view the post mortem. The mortuary manager was passionate about the facilities available to enable others to learn.

# Outpatients and diagnostic imaging

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

## Information about the service

Outpatient services are provided by Derby Hospitals NHS Foundation Trust at Royal Derby Hospital and London Road Community Hospital. In 2013/2014 there were 2,736 outpatient attendances each day, around 695,000 in total for the year. Outpatient services included a range of specialist medical teams, such as cardiology, respiratory medicine, urology, ophthalmology, and neurology. There was a diagnostic imaging service that included x rays and magnetic resonance imaging (MRI), computerised tomography (CT) and ultrasound scans.

We visited the outpatients department and diagnostic imaging service at Royal Derby Hospital and the outpatients department at London Road Community Hospital. We observed a range of clinics, including ophthalmology, physiotherapy, orthopaedic, general medical, surgical, and also the renal dialysis unit. We visited the diagnostic imaging services at the Royal Derby Hospital. We spoke with 36 patients during our visit and a range of staff including doctors, nurses, health care assistants, technical and clerical staff, porters, and volunteers. We observed interactions between patients and staff and reviewed performance information from and about the trust.

## Summary of findings

There were reliable systems, processes and practices in place to protect patients from avoidable harm and abuse. Risks to patients using the services were assessed and appropriately managed.

Patients' needs were assessed and their care and treatment were delivered in line with local and national guidance for best practice. Consent to care and treatment was obtained in line with legislation and guidance. Staff were suitably qualified and skilled to carry out their roles effectively and in line with best practice. There were good examples of staff working collaboratively to meet patients' needs.

Patients spoke positively of staff they came into contact with. Staff were observed to be caring and compassionate in the way they dealt with patients and their families or carers. They were knowledgeable and enthusiastic about the service they provided and this was reflected in how they engaged with people.

# Outpatients and diagnostic imaging

## Are outpatient and diagnostic imaging services safe?

Good



The outpatients and diagnostic imaging services had reliable systems, processes and practices in place to protect patients from avoidable harm and abuse. Staff knew how to report incidents, including abuse, and were supported to do this. Lessons were learnt from incidents and action was taken to improve services. Appropriate standards of cleanliness and hygiene were maintained. Patients were given sufficient information about the use of medicines and medicines were securely stored. Records were accurate, up to date and were kept securely.

Risks to patients using the services were assessed and appropriately managed. Staffing levels and skill mix were planned and implemented to meet patients' needs.

### Incidents

- Staff knew how to report incidents and gave examples of what they would report, such as accidents to patients, staff shortages and allegations of abuse. Staff told us that any member of staff could report incidents.
- Staff told us they usually had feedback from incidents they had reported. They said they were made aware of learning from incidents and gave examples of changes and improvements made. One example was an incident where a patient with diabetes had a plaster cast applied to their leg. The patient had diabetic neuropathy which meant they lacked sensation in their leg and so were not aware of damage being caused to the skin underneath the plaster cast. This was not discovered until the cast was removed. A new protocol was put in place for patients with similar conditions, including the application of a brightly coloured cast to alert staff.
- We saw that notifications of incidents relating to the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) were sent to CQC as required. These were usually incidents where a patient received exposure to radiation much greater than intended and greater than diagnostic reference levels. The incident notifications gave details of the action taken, including investigating the cause of the incident and explaining to the patient.

### Cleanliness, infection control and hygiene

- The clinics and areas we visited appeared clean. Cleaning schedules were in use and up to date for treatment rooms within clinics.
- Staff complied with trust policies regarding infection prevention and control. This included 'bare below the elbow' and hand washing policies. ('Bare below the elbows' is an initiative aiming to improve the effectiveness of hand hygiene practices performed by healthcare workers.)
- The eye clinics at Royal Derby and London Road Community hospitals had received an accreditation from the trust's infection prevention and control team. This was achieved following a rigorous assessment to ensure their infection control systems and procedures were safe and effective.
- In the renal dialysis unit, single rooms were used for patients who had infections or blood borne viruses. This was to protect other patients from the risk of infection. The same precautions were taken if patients had recently returned from travelling to certain countries or had been treated at other hospitals.

### Environment and equipment

- There were suitable arrangements in place to control the area and restrict access where x ray and imaging equipment was in use. This including warning signs for patients and staff and specialist personal protective equipment for staff.
- Where emergency equipment was in place, we saw that this was checked regularly to ensure the equipment was safe and in good working order.
- Diagnostic and screening equipment was maintained under contract with regular servicing carried out.

### Medicines

- Medicines were stored securely in locked cupboards with access restricted to nurses and doctors.
- Staff explained to patients about medication used in the clinics or prescribed to take at home. This included the purpose of the medication and any unwanted effects for the patient to look out for. Written information was given to patients about medication they were to take at home.
- The majority of outpatient prescriptions were dispensed at the retail pharmacy in the main entrance area of



# Outpatients and diagnostic imaging

Royal Derby Hospital. Although this was conveniently located, some patients reported long waits for their prescriptions and access problems for patients with limited mobility.

## Records

- Patient records were kept electronically and on paper. Records were in the process of changing to being electronic, though staff told us this was a slow process.
- Patient records were usually available when needed in the outpatient clinics. The reception staff managed the transfer of records in and out of the clinics. There was a tracking system in place to ensure that the location of individual records could be identified. Records were kept securely, usually behind the reception desk until needed then transferred to and from treatment rooms by staff.
- Missing records were reported to the clinical records staff who could usually track them down. If the records were not found, this was reported as an incident. Staff could prepare a temporary file for patients that included the most recent diagnostic and test results together with essential patient information. Staff acknowledged that this was not ideal, but it meant that the patient's appointment could go ahead as planned.
- The records we looked at were generally fully completed, accurate and up to date.
- Staff at London Road Community Hospital had developed separate patient (paper) records for use in the recently reorganised eye clinics. This was because there was a risk of loss or delay if they were relying on the patients' medical records being sent from Royal Derby Hospital for every clinic and then returned afterwards. Staff were using electronic notes alongside the paper records, but the information from the paper records was not always exactly duplicated electronically. This meant that if the patient was subsequently seen at Royal Derby Hospital, staff there may not have details of all treatment received at London Road Community Hospital.

## Safeguarding

- The trust provided three levels of safeguarding training to staff - awareness, standard and enhanced - depending on staff roles and responsibilities. Specific information was not available about how many staff working in outpatients had completed this training.

- Staff knew how to report any safeguarding concerns. They gave examples of concerns they had reported, including child protection issues.

## Mandatory training

- Staff showed us their individual training records which could be accessed on the trust's intranet. Staff could see when training was due and could book training for themselves. Staff told us there were no issues with being released for training.
- Specific information was not available about how many staff working in outpatients had completed their mandatory training

## Assessing and responding to patient risk

- There were emergency procedures in each clinic we visited, including call buzzers to alert other staff and resuscitation equipment available. Staff had received training in emergency life support.
- Staff carried out observations of patients as required, such as pulse and blood pressure. If patients were having treatment or tests, staff were aware of the possible effects. For example, patients having lung function tests in medical outpatients were observed in case they were dizzy or breathless afterwards.
- Female patients who were, or could be, pregnant were prompted to inform staff before exposure to radiation. Staff checked with female patients before carrying out x-rays.

## Nursing staffing

- The number of nursing staff was determined by the number of patients attending and the type of clinics being provided. Some specialist clinics required increased numbers of staff due to patient need and dependency.
- Most staff told us they felt the numbers of nursing staff and the skill mix usually met the needs of patients.
- Staff in one clinic expressed concern that there had been vacancies for two health care assistants since April 2014 with no active recruitment to these posts. The lack of these two staff had been effectively managed, but staff were concerned that this meant the staff would not be replaced.
- There was little use of agency staff in outpatient clinics as any gaps were usually covered by the permanent team. This was reflected in the overall downward trend in 2014 in the use of agency staff across the trust.

# Outpatients and diagnostic imaging

## Medical staffing

- Outpatient clinics were arranged by consultants to meet the needs of their specialities.
- Consultants were supported by trainee colleagues in some clinics, where this was appropriate.
- Junior doctors told us that there was always a consultant available for support in outpatient clinics. The junior doctors felt that the outpatient clinics were a good learning environment for them.
- Medical staff usually provided cover for colleagues when necessary so that clinics were not cancelled. Staff told us the use of locum medical staff was minimal.

## Major incident awareness and training

- There were comprehensive plans in the event of a major incident and to maintain business continuity. There was clear guidance for staff about who to contact and the action to take.
- Managers, sisters and senior staff we spoke with were aware of the major incident plan and their roles within it.

## Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Patients' needs were assessed and their care and treatment was delivered following local and national guidance for best practice. Consent to care and treatment was obtained in line with legislation and guidance.

Staff were suitably qualified and skilled to carry out their roles effectively and in line with best practice. Staff felt supported to deliver care and treatment to an appropriate standard, including having relevant training and appraisal. There were good examples of staff working collaboratively to meet patients' needs.

## Evidence-based care and treatment

- Guidance from the National Institute for Health and Care Excellence (NICE) was used to determine the care and treatment provided to patients. Examples of this included: patients with chronic hepatitis B were reviewed yearly in line with NICE guidance; the

treatment of patients with the eye condition diabetic macular oedema followed NICE guidance and was modified in line with national and international research findings.

- NICE and best practice guidance was available to staff through the trust's intranet.
- Staff were provided with regular updates when guidance was reviewed or practice changed.
- There were local protocols in place and followed by staff. One example was the pathway for patients who had been referred to the eye clinic for treatment of cataracts. The pathway was followed consistently and had been recently reviewed and updated.

## Patient outcomes

- The Cancer Patient Experience Survey 2012/2013 showed results in line with the national average or highest scoring ranges for most areas. This included average scores for patients believing they were seen as soon as they thought it was necessary and staff doing everything they could to control the effects of chemotherapy and radiotherapy.
- A local audit of specific treatment for the eye condition diabetic macula oedema showed significant improvement in the vision of patients. The audit was of treatment carried out from September 2013 to November 2014.

## Competent staff

- Staff received an induction when first employed by the trust. One nurse described their induction as "Excellent". They said they had all the information and orientation they needed during induction and were not left to learn the basics on the job.
- Staff told us about opportunities and training provided, other than mandatory training, to ensure they were competent in their roles. This included nurses and health care assistants working in surgical outpatients being offered opportunities to observe procedures in the operating theatre. The staff said they found this useful when explaining procedures to patients pre-operatively.
- Another example was nurse assessors in the age related macular degeneration (AMD) clinic who had received training from the consultant on reading scans of patients' eyes. Following training, the scans of 50 patients seen by the nurses were reviewed and checked by the consultant to check their competency.

# Outpatients and diagnostic imaging

- A health care assistant told us they were pleased they were able to pursue training in addition to mandatory training, “They’re very supportive here to help you to progress.”
- For the whole trust, the rate of staff appraisals completed had increased for 2013/2014 compared with 2012/2013. However, the rate for staff working in outpatients had declined each year.

## Multidisciplinary working

- Staff reported good team working between all disciplines and grades of staff. Staff in the eye clinic at London Road Community Hospital told us they felt well supported by the ophthalmic consultant. Patients attending for renal dialysis were reviewed monthly by a multidisciplinary team including the consultant, specialist nurse and dietician. Physiotherapists and occupational therapists worked closely together in the clinic for patients with musculoskeletal problems. We saw evidence of multidisciplinary working in patients’ notes and in minutes of team meetings.
- There were ‘one-stop’ clinics provided with staff of different disciplines working together. For example, patients referred for assessment and treatment of cataracts were seen by a consultant, a nurse, and also had any necessary tests, such as blood tests, all in one appointment. There was a one stop clinic for patients having renal dialysis who had fistula problems. (The fistula is a surgically created communication between a vein and an artery, usually in the arm, allowing the transfer of blood into the dialysis machine and back again). Patients were seen by a nurse and a vascular surgeon in this clinic.
- Letters to patients’ GPs were sent following outpatient appointments to give details of the treatment given and planned. Staff said there were sometimes delays in getting letters signed by consultants. The aim was for the letters to go out within seven days, but staff told us that it sometimes took up to 14 days for some clinics. Two patients spoken with felt that communication between the hospital and their GP was not timely or effective and had led to delays in treatment.

## Seven-day services

- The majority of outpatient clinics operated between Monday and Friday each week. There were some regular Saturday clinics, including eye and hand clinics. Some specialities, such as urology, were running additional Saturday clinics to address waiting lists.
- X rays for outpatients were available Monday to Friday until 5pm. Weekend cover was provided by a resident registrar radiologist from 11am to 11pm each day and a consultant radiologist available during each day and on call overnight.
- The renal dialysis service was provided Monday to Saturday with an on-call emergency service on Sundays.

## Access to information

- The Cancer Patient Experience Survey for 2012/2013 results were in the highest 20% of all NHS trusts for doctors having the patient’s notes and other relevant documentation when seeing outpatients or patients attending for day case treatment.
- X ray and diagnostic imaging results were available electronically which made them promptly and readily accessible to staff.

## Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- Staff demonstrated confidence and competence in seeking consent from patients. Staff were able to explain the benefits and risks of treatment in a way that patients understood.
- Staff were aware of their duties and responsibilities in relation to patients who lacked mental capacity. Staff knew the procedures to follow, including involving other professionals, so that a decision could be made in the patient’s best interests.

## Are outpatient and diagnostic imaging services caring?

Good



Patients were treated with kindness, dignity, respect and compassion when receiving care and treatment. Patients spoke positively about how they were treated by staff.

Patients, and those close to them, were included and encouraged to be involved in making decisions about their care and treatment.

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## Compassionate care

- Patients spoke positively about all the staff they came into contact with. One patient commented that the reception staff, “Are so friendly. They know me now, I’ve been coming here so long, they greet me by name with a smile.” A patient in the renal dialysis unit said, “The staff get everything ready for me, they know how I like things. These small details are so important.”
- We received positive comments before the inspection from patients about the care provided: “The care given to me in orthopaedic outpatients is fantastic and I hope this continues” and, “I visit various clinics for sleep, hearing, vision, carpal tunnel and all are consistently polite, well organised and effective.”
- We observed a receptionist in the renal dialysis unit ensuring a patient had something to eat because their transport home was delayed and the patient had diabetes. The receptionist then received a call from the patient’s relative and reassured them that the patient was now on their way home and had eaten.
- Staff in the eye clinics told us that delays in transport home could cause distress and anxiety for some patients, particularly older people or those with long term health conditions. Staff had used funds raised to pay for taxis home, rather than have patients waiting for delayed ambulance transport.

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

- Most patients told us they felt involved in making decisions about their care and treatment. One patient said, “They’re good at explaining what to expect, the treatment and the tests and what happens afterwards.” Another patient said, “The physio explained what would be involved and the exercises to do in between.”
- Two patients attending for physiotherapy told us they felt they had not been involved in planning their care and treatment. One said they had received, “Good care and attention” but, “I don’t feel listened to regarding my needs and care planning. A treatment plan would be good to have.”
- We observed staff ensuring that patients understood their planned treatment and offering opportunities to ask further questions. Some staff used clinical language and technical terms when talking to patients which some may find difficult to understand.

- Patients told us they knew how to contact the clinic if they were worried about their condition or treatment after they left hospital. We spoke with patients who had done this and had received appropriate advice and support.

## Emotional support

- There were specialist nurses who supported patients hearing bad news about their health condition, such as a specialist lung cancer nurse.
- A patient in the eye clinic said, “I don’t like having the injections, but the nurse always stays with me for reassurance. It’s comforting.”
- Carers of patients with a learning disability or those living with dementia were able to attend clinics with the patient. The carer of a patient with a learning disability attending for renal dialysis told us they were always made welcome by staff. The carer said, “The staff are cracking. They are really good with [patient's name] and have a laugh with her.”

## Are outpatient and diagnostic imaging services responsive?

Good



Outpatient and diagnostic imaging services offered a range of clinics that were planned and delivered to meet the needs of the local population. This included x ray clinics at Royal Derby and London Road Community hospitals plus satellite clinics in local community hospitals.

The needs of different people were taken into account in the planning and delivery of services. There was an interpretation service available for patients who did not have English as their first language. Reasonable adjustments were made for patients with a learning disability, those living with dementia, and patients with limited mobility.

The environment of most clinics was suitable for patients using it, except for a general lack of facilities for children and the lack of space in one waiting area.

Patients mostly had access to the right care at the right time. Action was being taken to address waiting times for urgent and new routine appointments and backlogs in follow up appointments.

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There was information available to patients about how to make a complaint. Complaints and concerns were taken seriously, responded to in a timely way and appropriate action taken.

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

- The trust provided a range of outpatient clinics to meet the needs of local people. This included rapid access clinics and two week wait cancer clinics for patients needing more urgent assessment and treatment. Clinics were provided at Royal Derby and London Road Community hospitals.
- Most patients who were referred by their GPs for an x-ray were seen at London Road Community Hospital. There were also x-ray clinics held at community hospitals in local towns. Other patients requiring x-rays or scans were seen at Royal Derby Hospital.
- The outpatient clinics at both hospitals were clearly signed. There was a team of volunteers at Royal Derby Hospital to assist patients to find clinics. The volunteers also helped within clinics, such as the eye clinic, to assist patients to find the correct waiting areas.
- Blood tests and electrocardiograms (recordings of heart activity) were carried out within some clinics so that patients did not have to go elsewhere. Similarly, physiological measurements for respiratory patients were carried out within the clinic or in another clinic very nearby. These tests were usually arranged to be carried out on the same day as the patient's appointment with the doctor.

## Access and flow

- The national standard for NHS trusts is that 95% of non-admitted patients should start consultant led treatment within 18 weeks of referral. The trust had exceeded this target in May, June and July 2014, but had not met it in August (93%), September (91%) or October (93%).
- The ratio of new patients to follow up patients attending varied for each clinic. The number of follow up appointments will have a bearing on how many new patients can be seen and so will have an effect on meeting the 18 week standard. The overall rate for the trust of new to follow up patients seen was worse than the England average, though this had improved in the last quarter.

- The overall rates for the trust for patients who did not attend, (without prior cancellation) for their appointment was better than the England average. Patients who did not attend were referred to the consultant for a decision about whether to offer another appointment.
- The number of appointments cancelled by patients was worse than the England average. The reasons for cancellation were recorded and analysed by the trust. More than a third of cancellations were recorded as 'patient choice' or 'other – patient cancellation'. This did not provide specific detail of why patients had cancelled their appointments.
- Patients could change appointments using an online system. Some patients said there were difficulties when trying to change an appointment online and this resulted in cancelling the original appointment and making a new one.
- The number of appointments cancelled by the trust was worse than the England average. The reasons for cancellation were recorded and analysed by the trust. The largest number of cancellations was recorded as 'appointment made in error'.
- The trust had recognised the issues related to the cancellation of appointments. They had started on a programme of outpatient transformation and had appointed a senior manager to facilitate this.
- There were measures being taken to reduce waiting times for patients, for example, additional clinics were being held on Saturdays to address the waiting lists in some specialities and patients having renal dialysis were reviewed monthly while attending for dialysis. This avoided the need for a separate outpatient appointment.
- Ophthalmology was one of the largest clinics provided. Clinics ran at Royal Derby and London Road Community hospitals. Staff had identified that there was a growing number of patients requiring treatment for eye conditions, particularly age related macular degeneration, (AMD). In response to the increasing numbers of patients, the service was being re-organised. The first phase of this had been completed with a move of some AMD clinics to London Road Community Hospital. Patients and staff at both sites viewed this as a positive move.
- The national standard for NHS trusts is that patients requiring an appointment for investigation of suspected cancer should be seen within two weeks of an urgent



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referral by their GP. For the second quarter of 2014, (July to September), the trust rate of patients being seen within two weeks was very similar to the national rate, (around 94%). The trust told us the rate had improved from October to December 2014, though this could not be fully clarified until after the end of December 2014.

- Patients diagnosed with cancer should wait 31 days or less from diagnosis to first treatment to meet the national standard for NHS trusts. The trust had met the national rate from July to September 2014. The trust told us the rate had reduced to slightly below the national rate from October to December 2014, though this could not be fully clarified until after the end of December 2014.
- We heard mixed comments from patients about how long they had waited for their first appointment (non-urgent appointments). Most patients were satisfied with the length of time from referral to being seen in outpatients. One patient in the eye clinic said, "I saw my GP about five weeks ago and now I'm here for my cataracts." Some patients felt they had waited too long or longer than expected. One patient attending for physiotherapy said they were referred in July but not seen until November, (approximately 18 weeks). They felt their condition had deteriorated during that time.
- Most patients told us they could usually get a routine appointment at a time to suit them. They could choose to have text message reminders for appointments.
- Patients could change or cancel appointments using the trust's website, though this was not available for x-ray or imaging clinics.
- Patients we spoke with had mixed experiences of how long they were kept waiting once they had arrived for their appointments. Some patients said they were usually seen at the appointment time, sometimes a little earlier. Other patients said they always expected to wait beyond their appointment time. Patients in the newly re-organised eye clinics were pleased with the reduction in numbers of patients and consequently reduced waiting times.
- Most clinics we visited had a display on a television screen giving details of current waiting times. The seating arrangements in some waiting areas meant that some patients were facing away from the television screen and so could not see the information.
- We observed staff informing patients of waiting times and the reason for any delays. Some patients we spoke with said they were not usually informed about the reason for delays.
- Most patients were accepting if they had to wait beyond their appointment time. One patient said, "You have to think that it's because doctors need to spend more time with some people, and that could be you. You wouldn't want to be rushed."
- The emergency eye clinic was open to direct referrals from GPs and opticians. The referrals were assessed by a nurse to identify patients in most urgent need. Patients were contacted directly to be offered an appointment, usually on the same day or the following day. Staff told us there were usually 20 - 30 patients attending the emergency eye clinic each day, including patients referred by the accident and emergency department.
- There were virtual clinics for some surgical specialities. The referrals made by GPs were checked daily and patients were assessed as needing to be seen in clinic or to be sent for tests. Patients were contacted directly to arrange an appointment. This avoided some patients having to attend for two appointments.
- Some patients attending the eye clinic told us the letter with information about their appointment did not include how long the appointment was likely to take. They felt this information should be included so they could properly plan their visit. Similarly, patients who required an x-ray before their appointment were not given an indication of how long to allow for this.
- The length of time patients were waiting for their appointment once in the clinic was not consistently monitored by the trust during 2013/14. This was being rectified for the start of the new 2015/16 financial year.
- The number of hospital cancelled appointments was 9%, which was worse than the national average of 6%. The trust monitored the number of times patients records were not available for their appointment. Data for December 2014 and January 2015 showed this was around 1.5% of the total attendances through outpatient clinics. No clinic appointments were cancelled as a result of not having the records.

## Meeting people's individual needs

- Patients who did not have English as their first language told us they were usually offered an interpreter when



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they booked an appointment. Staff we spoke with in all the clinics knew how to access an interpreter, by telephone or in person. There were staff in some clinics who were able to interpret for certain languages.

- There was a weekly clinic for the assessment and treatment of patients with tuberculosis. An interpreter was always booked for this clinic as staff knew many patients attending would not have English as their first language. (The incidence of tuberculosis is known to be significantly higher among the non-UK born population).
- Patients with a learning disability or those living with dementia were usually prioritised and seen promptly so that waiting did not cause undue distress. If attending for a pre-operative assessment, these patients were usually offered a double appointment to allow sufficient time for assessment and explanations.
- There was a nurse led audiology clinic specifically for patients with a learning disability. The clinic was limited to eight patients who were given appointments of 20 to 30 minutes each, rather than the standard ten minutes. This was to allow sufficient time for effective communication and explanation.
- Information for patients in the eye clinics was displayed in large black print on a yellow background and staff name badges were in the same format. This format is easier for people with a visual impairment to read.
- Appropriate equipment and facilities were provided for patients who attended for assessment and treatment of obesity. An exception to this was the hydrotherapy pool at Royal Derby Hospital. This could not be used for patients who weighed more than 20 stone.
- Patients with mobility issues could use the internal transport provided by volunteers at Royal Derby Hospital. This was an important service for patients who would have difficulty in walking the distances involved from the main entrance to some of the outpatient clinics. One patient waiting for the volunteer transport told us, "I couldn't do without it. I come on my own so there's no-one to push me in a wheelchair. Anyway, I prefer a ride in the buggy!"
- The clinics we visited provided waiting areas with sufficient space and seating, accessible toilets, and water or a drinks machine available. One exception to this was the clinic for patients with neurological conditions at London Road Hospital. The clinic was

located in what had previously been a hospital ward and the waiting area was a corridor. This was cramped and uninviting, allowing little space for patients with limited mobility or those using wheelchairs.

- Most of the clinics we visited did not have separate waiting areas for patients with children. There were toys available in some clinic waiting areas. Children could be referred for treatment in the emergency eye clinic at Royal Derby Hospital but there was no specific waiting area for them. Staff said children would be prioritised as far as possible so would not be waiting too long.
- In the eye clinic at Royal Derby Hospital, we saw that a drug cupboard was located in a room used for the treatment of patients. This meant that nurses came into the room to access the drugs cupboard whilst patients were being seen. We observed several such interruptions for one patient who was having treatment in this room.
- A patient commented before our inspection that the retail pharmacy at Royal Derby Hospital did not have the capacity to cope with the number of prescriptions presented. The patient said the pharmacy, "Is cramped and it is extremely difficult for a disabled person to get to the counter to hand in a prescription. There is not sufficient space for people to wait for prescriptions, and it is difficult to get through the crowd of people waiting to actually collect your medicine. It is difficult for shoppers, as the shop is always crowded with people waiting for prescriptions. It can take over an hour to get your medicine, and this just adds to the high cost of car parking." A patient at our listening event and patients we spoke with during our inspection visit expressed similar views.
- There were rooms available in clinics for discussing sensitive issues or breaking bad news to patients and their relatives / carers.

## Learning from complaints and concerns

- Information for patients about making complaints, raising concerns or giving compliments was displayed in all of the clinics we visited and also in other public areas of the hospital.
- Information from the trust showed there were six complaints in the last 12 months related to outpatient clinics. These were mostly about the attitude of staff, communication and waiting times.
- Complaints were appropriately responded to. Investigations were carried out and complainants

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received a formal written response from the trust. Action was taken to improve the service, such as employing additional staff for extra clinics to reduce the waiting list and waiting times for patients.

- Staff in the clinics reported a low level of complaints. Information was displayed about how patients could complain or make comments about the service they received. Staff in one clinic said they had tried using a comments box but this had not proved successful. Patients could use the trust's website to make complaints or leave comments.
- Only one of the patients we spoke with had made a formal complaint to the trust. They felt this had been dealt with promptly and fairly.

## Are outpatient and diagnostic imaging services well-led?

Good



The trust's vision statement was prominently displayed in all areas of the hospitals. Staff working in outpatient and diagnostic imaging services were aware of the trust's vision and demonstrated commitment to its objectives and values.

There were suitable arrangements to identify and manage risks, and to monitor the quality of the service provided.

Staff felt well supported by their immediate managers. They felt encouraged to bring ideas for improvements to services. Staff were proud of the standard of care they provided and of their achievements.

### Vision and strategy for this service

- The trust had a clear vision statement displayed prominently in all areas of the hospitals, including outpatient clinics.
- Staff we spoke with were aware of the trust's vision and demonstrated commitment to its objectives and values.
- Staff were aware of the strategy for their clinics or departments, but not of any specific objectives for the outpatients service as a whole.

### Governance, risk management and quality measurement

- Consultants attended regular governance meetings in their own specialities. Issues relating to the outpatients service, such as complaints and waiting times for patients, were discussed and action planned.
- There were two risks related to the outpatient service identified on the trust's risk register: a large number of follow-up patients in urology at risk of delayed treatment due to lack of clinic capacity, and the risk of failure to achieve the 18 week target for patients waiting for treatment. We saw that action was being taken in response to these risks with new staff employed and additional urology clinics being held.
- There were quality assurance measures in place, such as local audits of cleanliness and checks of the environment. Measures to encourage more patient feedback were being developed in the outpatient service.

### Leadership of service

- Staff told us they felt well supported by their line managers. A senior nurse in one clinic told us they had good support from their manager, "He's very stretched but he'll pop in several times in the week and he's always available on the phone." A receptionist said their manager was, "Really approachable. She will always stand up for us."
- Staff were aware of the chief executive and the senior management team. Most staff were positive about and expressed confidence in the senior management team.

### Culture within the service

- Staff we spoke with were proud to work at the hospital and were keen to tell us about their work and achievements. A health care assistant told us, "I love working here. It's quite inspirational working in this team – there are a lot of very experienced staff."
- Many of the staff we spoke with had worked for the trust for five years or more. Some staff were even longer long serving and were proud to tell us this.
- Staff in the eye clinics were proud that their department had achieved an accreditation from the infection prevention and control team. They were pleased that this had been recognised as an achievement by senior management and had been mentioned in the trust intranet and newsletter.

### Public and staff engagement

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- A trial of a range of patient feedback methods had started in some outpatient areas. This included patients commenting by text message, online, or using postcards designed for specific areas. Leaflets had been produced to go out with patient appointment letters to inform them of the ways to give feedback.
  - Most patients we spoke with had not raised any concerns with the trust. One patient told us they had raised an issue about cleanliness and felt the provider had taken appropriate action.
  - Staff told us they felt communication had improved with senior management in the 12 months before the inspection. They were aware of opportunities to contact and meet with the chief executive, though the majority of those we spoke with had not done this.
  - Staff told us they had opportunities to raise issues or bring ideas for improvement and they felt listened to. A consultant said, "The business approach is good here. We can put a case for improvement and we're listened to." A health care assistant told us they were pleased their ideas were listened to and they had been supported to make changes to improve the service for patients.
  - We heard from staff about improvements being made that had been driven by them. Nurses in the eye clinic had identified gaps in the existing pathway and documentation for patients having cataract surgery. They had worked together to produce a new version of the documents and were about to start using this for a three month trial. Staff involved in the re-organisation of the eye clinics felt they had been involved and consulted and had been able to put their own ideas into action.
- Innovation, improvement and sustainability**

# Outstanding practice and areas for improvement

## Outstanding practice

- The Certificate of Eligibility of Specialist Registration (CESR) project work in the emergency department enables recruitment of middle grade doctors at a time of national shortage and offers career progression for this staff group.
- The frail elderly assessment team (FEAT) in the Medical Assessment Unit (MAU) provided care and treatment targeted at people living with dementia. The team included a pharmacist with the aims of optimising the use of medicines and had a lounge area that provided a calm and safe environment.
- Ward 205 is to be commended for helping to improve the mental wellbeing of the elderly patients and patients with dementia through use of the reminiscence room, pictorial information and advanced service planning to further enhance care.
- The maternity department bereavement service had been recognised by the Royal College of Midwives. The lead midwife had been nominated for the Royal College of Midwives Award 2015 National Maternity Support Foundation Award (NMSF) for Bereavement Care, improving the environment, which was known to be an important key to effective bereavement care.
- The KITE (kids in their environment) team provided an innovative outreach support service to children with chronic conditions in their homes. The service had proved popular and they were expanding and developing the service as a result. This included employing a youth worker for the team.

## Areas for improvement

### Action the hospital MUST take to improve

- The trust must ensure that patient moving and lifting equipment on medical wards is checked and serviced at least six monthly to ensure they are safe for use.
- The trust must ensure that patients' notes are stored securely to ensure that confidential patient information is not accessed inappropriately.
- The trust must have suitable arrangements in place to ensure that sufficient and suitably qualified staff are on duty on all medical wards to meet patients' needs safely.
- The trust must ensure that the lone working policy and arrangements for community maternity staff are reviewed to ensure they feel safe and secure when out in the community.
- The trust must ensure the named midwife process is reviewed and improved to ensure it is implemented consistently,
- The trust must ensure that all maternity records are completed as soon as possible following an event so as to avoid evidence being written retrospectively.
- The trust must ensure that all staff have a working knowledge of the Mental Capacity Act 2005 and

understand its implications for their practice; patients thought to have reduced or lack of mental capacity to consent to their care and treatment must receive prompt and effective assessments in line with the Act.

- The trust must ensure all DNACPR order forms are completed accurately in line with trust policy.

### Action the hospital SHOULD take to improve

- The trust should ensure that there are sufficient numbers of suitably qualified, skilled and experienced nursing staff on the adult emergency observation ward to safeguard the health, safety and welfare of patients.
- The trust should ensure that appropriate analgesia is administered promptly to patients in line with national standards in the emergency department.
- The trust should consider whether there is clear signage in the emergency department.
- The trust should ensure that there is sufficient storage available to enable equipment to be appropriately stored and enable safe access to bathrooms on medical wards.
- The trust should consider providing information for patients and friends and family comment cards in different formats and different languages. This will

# Outstanding practice and areas for improvement

enable people with learning disabilities, those who's first language is not English or those with cognitive impairment to access information and provide their feedback.

- The trust should review arrangements for undertaking venous thromboembolism (VTE) assessments on the surgical assessment unit.
- The trust should consider improving the process for emergency urology admissions to ensure patients are seen in a timely manner.
- The trust should ensure arrangements are reviewed for the care of patients on high dependency units who would be categorised as level two as current arrangements are not meeting the . 'Core Standards for Intensive Care Units 2013.
- The trust should ensure all areas of the critical care service participate in the national intensive care audit programme (ICNARC).
- The trust should consider developing their electronic prescribing system to enable it to be used in intensive care as for other wards and departments in the hospital. The use of different systems across the hospital meant there was a risk of poor communication about previously administered medications.
- The trust should ensure that staff on Puffin ward are trained and supported to care for patients who require a CAHMS assessment whilst on the ward so that they can ensure their welfare and the welfare of other patients is protected.
- The trust should ensure that discharge processes start at an appropriate stage of a patient's care, so that discharges are not delayed due to the unavailability of care packages or equipment.
- The trust should ensure that all clinical single use equipment is stored safely and appropriately; and disposed of when it has expired it used by date.
- The trust should ensure that the design and layout of the neurology outpatient clinic at London Road Hospital is suitable for the needs of all patients, including those with limited mobility.
- The trust should consider improving the facilities for patients who need to collect prescription medicines from the pharmacy within Royal Derby Hospital. This is to reduce the long waiting times for prescriptions to be dispensed and the pharmacy and improve access for patients with limited mobility.
- The trust should review the information provided in appointment letters sent out to patients to ensure it provides sufficient information about how long to allow for appointments.

## Compliance actions

### Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records</p> <p>The registered person must ensure that the service users are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of – (a) an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user.</p> <p>DNACPR order forms were not recorded accurately in line with trust policy. This generated the risk to the delivery of safe patient care and treatment.</p>
Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing</p> <p>The registered person must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified skilled and experienced persons employed for the purposes of carrying on the regulated activity.</p> <p>There were occasions when there were not sufficient numbers of suitably qualified, skilled and experienced nursing staff on the Medical Assessment Unit, the Stroke Unit and the Nightingale Macmillan unit.</p>