Torbay and South Devon NHS Foundation Trust

RA9

Community urgent care service

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RA954	Brixham Hospital	Minor Injuries Unit	TQ5 9HN
RA956	Dawlish Hospital	Minor Injuries Unit	EX7 9DH
RA957	Newton Abbot Hospital	Minor Injuries Unit	TQ12 2TS
RA958	Paignton Hospital	Minor Injuries Unit	TQ3 3AG
RA979	Totnes Hospital	Totnes Hospital	TQ9 5GH

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

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

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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

We have rated urgent care services in the minor injuries units as good overall because:

- Openness and transparency about safety was encouraged. Lessons were learned from incidents and communicated widely to support improvement.
- Safeguarding of vulnerable adults and children was well understood and implemented.
- Risks to people who used the department were assessed, monitored, and managed on a day-to-day basis. Staffing levels and skill mix were planned, implemented and reviewed.
- All minor injury units were well maintained and well equipped. However, the servicing and replacement of some equipment was not always up-to-date.
- Care and treatment was planned and delivered in line with current evidence-based guidance and best practice.
- Staff were well qualified, competent and demonstrated the skills required to carry out their roles effectively. They worked collaboratively with multidisciplinary teams from community services and acute services in order to ensure the best outcomes for their patients.
- Feedback from patients and those close to them confirmed that staff were caring and kind. Communication with children and young people was age appropriate and thoughtful.
- Each minor injury unit was easy to access and there was sufficient space for the number of people using them.
- 99.8% of patients were treated, discharged or transferred within four hours during 2015. The average time to treatment was 23 minutes.
- People with dementia or learning disabilities received care and treatment that was sympathetic and knowledgeable.
- It was easy for people to complain or raise a concern and they were taken seriously when they did so.
- The minor injury units had an effective and cohesive leadership team who identified with a strategy of delivering more care and treatment in a community setting.
- Governance arrangements were well structured with risks and quality being regularly monitored and action taken if necessary.

However:

- X-ray services were not always available when patients needed them. At Totnes, Brixham and Paignton the X-ray departments were only open for half days for much of the week. There were no X-ray services at weekends which meant that patients had to go to the emergency department at Torbay if a fracture was suspected.

Summary of findings

Background to the service

Torbay and South Devon NHS Foundation Trust currently runs five minor injury units (MIUs) located in community hospitals at Brixham, Dawlish, Newton Abbott, Paignton and Totnes. These are nurse-led units staffed by emergency nurse practitioners and minor injury practitioners who receive specialist training to treat injuries and conditions within the scope of practice of a minor injury unit.

A consultant nurse who also provides clinical leadership manages the units. In July 2015 the units were linked by a new clinical computer system that allows patient activity to be monitored in real time. Between them the MIUs saw 32,000 patients in the year ending December 2015.

We visited between 2 and 5 February 2016. During this inspection we observed care and treatment of patients, looked at 12 treatment records and reviewed performance information about the department. We spoke with approximately 15 members of staff including nurses, receptionists, managers and support staff.

Our inspection team

Our inspection team was led by:

Chair: Tony Berendt, Medical Director, Oxford University Hospitals

Head of Hospital Inspections: Mary Cridge, Care Quality Commission

The team inspecting the urgent care services included two CQC inspectors and two specialist advisors who all had experience of minor injuries units.

Why we carried out this inspection

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

How we carried out this inspection

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

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

We undertook an announced inspection of Torbay and South Devon NHS Foundation Trust on 2-5 February 2016.

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. During the visit we held focus groups with a range of staff who worked within the service. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

Summary of findings

Good practice

Following review of unplanned re-attendance rates, by January 2016 all units were better than the national average. Dawlish had reduced its unplanned re-attendance rate to 0.6% and the highest, Paignton, was only 2.9%.

There was an orientation programme for nurse practitioners lasted for a minimum of four weeks and practice during this time was always supervised.

The trust had been selected by NHS England to become one of eight urgent and emergency care vanguards which are aimed at improving the coordination of urgent and emergency care services. Planning had started to expand the MIU services at Newton Abbot so that minor illnesses could also be treated.

The majority of staff had undertaken training in the specific needs of people with dementia and learning disabilities and the involvement of families was encouraged. The computer system featured a flagging system for people with learning disabilities so that staff could be alerted to their special needs. We observed a patient living with dementia being given extra time during treatment to enable them to understand what was happening. Clear and simple explanations were given and calmly repeated in order to reassure the patient. We observed the treatment of a patient with learning disabilities. Care was provided in a quiet part of the unit so that their exposure to the unfamiliar and confusing environment of a hospital was kept to a minimum. Their particular needs were carefully discussed with them and their carers and treatment was provided accordingly.

A trauma triage system had been introduced which reduced the need for long journeys for people who had sustained fractures. Clinical notes and X-rays were viewed electronically by an orthopaedic consultant in the acute trust. Following this review many patients could continue their treatment at their local minor injury unit. Only people with more complicated fractures were asked to travel to Torquay for specialist treatment.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- Ensure that all equipment is serviced and replaced in a timely fashion.
- Ensure where patients have an allergy to penicillin they are able to be prescribed appropriate antibiotics without delay.
- Review the provision of X-rays services to ensure they are always available to patients in each minor injury unit.
- Ensure there is a system in place to review waiting times for initial assessment.

Torbay and South Devon NHS Foundation Trust

Community urgent care service

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated the emergency and urgent care services as good for safety because:

- Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- Adverse impacts on patients following safety incidents had reduced significantly in the last year. Lessons were learned from incidents and communicated widely to support improvement. Safeguarding of vulnerable adults and children was well understood and implemented.
- Risks to people who used the department were assessed, monitored and managed on a day-to-day basis. These include signs of deteriorating health, medical emergencies or risks to mental health.
- Staffing levels and skill mix were planned, implemented and reviewed. There were sufficient staff to treat and care for the patients that attended the minor injury units. Any temporary staff shortages were responded to quickly and appropriately. The majority of staff had received up-to-date training in safety systems. The environment of the units varied, depending on the age of the building in which they were situated. All were visibly clean, well maintained and well equipped.
- The servicing and replacement of some equipment was not always up-to-date.
- The minor injury units formed part of the trust's response to major incidents. They would receive and treat people with minor injuries via the ambulance service. Recent training had taken place in order to prepare the staff for this role.

Incidents

- All staff that we spoke with were aware of their responsibilities in reporting incidents and we saw examples which had been submitted. Staff understood the value of reporting 'near misses' and described examples of these.
- Incidents and accidents were reported using a trust wide electronic system. All staff had access to this and knew which incidents required reporting.
- There were 62 incidents across all Minor Injury Units in the year ending 31 January 2016. None of them were

assessed to be serious incidents. They had been logged appropriately, were clearly described and appropriate remedial action had been taken when necessary. For example, a new clinical protocol had been developed for the management of people with spinal injuries who have been driven to an MIU in a car.
- Learning from incidents was discussed and recorded at governance meetings and staff meetings.

Duty of candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a new regulation which was introduced in November 2014. This Regulation requires the trust to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds. This is known as the duty of candour. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person', within 10 days.
- Staff that we spoke with understood the principles of openness and transparency that are encompassed by the duty of candour. We were told that the electronic reporting system automatically alerted staff when an incident is subject to the duty of candour.

Cleanliness, infection control and hygiene

- Each MIU appeared clean and tidy. Hand washing facilities were readily available and we observed staff wash their hands before and after patient contact. This helped to prevent the spread of infection. This complies with NICE quality standard 61 statement 3.
- Hand hygiene audits took place monthly and consistently showed compliance of between 98% and 100%. The 'bare below the elbow' policy was adhered to.
- Cleaning schedules were displayed in clinical and public areas. We were shown an up-to date cleaning programme for children's toys at Newton Abbott and Totnes.
- Staff were aware of the actions necessary to look after someone with, or who may have been involved in, the recent Ebola outbreak. There were notices in the entrance asking people to inform the receptionists if they had recently travelled to the affected countries.

Environment and equipment

- The MIUs were located in buildings that varied from Victorian to relatively modern (less than eight years old). The fabric of the buildings were well maintained. The design of some of the buildings meant that patients in the waiting rooms could not always be observed. This was particularly so at Dawlish and meant that a patient's condition could deteriorate without staff being aware. The waiting room at Paignton could not be directly observed but it was possible for receptionists to hear any activity that was taking place.
- All the MIUs were well equipped and the equipment was checked daily to ensure that it was ready for use. We saw maintenance records showing a regular programme of maintenance and servicing. However, the medical suction machines at two units were overdue for their planned maintenance check.
- There was a comprehensive range of resuscitation equipment for both children and adults. This was stored in tamper-evident resuscitation trolleys which were checked weekly, in line with trust policy. Despite this a paediatric resuscitation mask at Dawlish MIU was found to be out of date. We bought this to the attention of the nurse in charge who took immediate action to replace the mask.
- The arrangement of the equipment in the trolleys was the same in all the units. This meant that staff who rotated between different units always knew where each item of equipment could be found.
- Apart from Paignton, all waiting rooms had specific areas for children to wait. There was a selection of toys for a variety of age ranges. We were told that there used to be toys in the waiting room at Paignton but they had recently been stolen. Consideration was being given to toys that could be fixed to the walls.
- All treatment rooms contained a box of toys to distract and occupy children during examination and treatment.

Medicines

- Medicines were stored correctly in locked cupboards or fridges. Controlled drugs and fridge temperatures were regularly checked by staff working in the department and seen to be within required parameters.
- Unused medicines were disposed of in accordance with hospital policy.
- Allergies were clearly recorded and antibiotics were prescribed according to local protocols.
- Some Emergency Nurse Practitioners were trained as nurse prescribers so that they could supply and

administer certain medicines. There were also Patient Group Directions (PGDs) in place. PGDs are agreements which allow some registered nurses to supply or administer certain medicines to a pre-defined group of patients without them having to see a doctor. We saw evidence that staff had been appropriately assessed and signed off as competent to use PGDs.

- New PGDs had to be approved by the trust's PGD group. It had only approved two antibiotics for infected wounds, both from the penicillin group of antibiotics. This meant that patients who were allergic to penicillin could not immediately be given the most appropriate medicine. Instead, they were referred to a GP for a prescription.

Records

- All MIUs shared the same electronic patient record system which also linked to the emergency department at Torbay hospital. This meant that records from visits to other units could be accessed immediately.
- As well as recording basic demographic information, the system also contained clinical templates that helped practitioners to collect all the information needed to achieve an accurate diagnosis.
- Risk assessments for items such as allergies or mental health problems were an integral part of the system. We looked at 12 patient records (two or three in each unit) and found that risk assessments had been completed where appropriate.
- Access to the system was controlled by individual passwords. This also helped to ensure that the name of the practitioner and the time that they saw each patient was accurately recorded.

Safeguarding

- Staff that we spoke with were familiar with processes for the identification and management of adults and children at risk of abuse. They understood their responsibility to report concerns.
- Training of staff regarding child and adult safeguarding issues was seen as a priority. Records showed that all staff had received up-to-date training. Nurses and healthcare assistants undertook the more advanced level three training which demonstrates a higher standard than many other MIUs and emergency departments.
- Additional training in child sexual exploitation had taken place in response to local concerns.
- Children who were on the 'At risk' register were automatically flagged on the MIU computer system. This could only be viewed by clinical staff in order to protect confidentiality. We were told that the 'At risk' register was updated daily by the Torbay child safeguarding team.
- The clinical computer system ensured that a child's attendance record could not be completed until consideration had been given to safeguarding issues. There was a detailed risk assessment available if there was a possibility that a child was at risk. This linked to a proforma for referral to the local safeguarding team if necessary.
- The MIU lead nurse for children attended local safeguarding meetings. We were told that there had been discussions recently in order to agree new procedures for the reporting of female genital mutilation. The lead nurse updated staff on child protection issues at regular staff meetings.

Mandatory training

- There were a wide range of topics included in mandatory training. For example, conflict resolution, dementia, falls prevention and information governance. This was in addition to fire training, waste management and infection control.
- Staff were trained to deal with life threatening emergencies. All clinical staff were trained to deliver intermediate life support (ILS) to both adults and children. Three staff had advanced life support (ALS) qualifications and one was an ALS instructor.
- Some of the topics were covered by e-learning and others took place during mandatory training sessions which were tailored to the specific needs of the staff attending.
- At the time of our inspection 98% of staff had completed training in the last year. The trust's target was 95%.

Assessing and responding to patient risk

- During our inspection patients were assessed promptly on arrival at the MIUs. We monitored this by direct observation and by looking at a random sample of 31 attendance records. Guidance from the Royal College of Nursing and the Royal College of Emergency Medicine (RCEM) (Triage Position Statement, April 2011) states that patients should be rapidly assessed on arrival in order identify or rule out life/limb threatening conditions and ensure patient safety. This is often

referred to as triage. It should be a face-to-face encounter which should occur within 15 minutes of arrival or registration and assessment be carried out by a trained clinician. This ensures that patients are directed to the appropriate part of the department and the appropriate clinician. It also ensures that serious or life threatening conditions are identified or ruled out so that the appropriate care pathway is selected. It was not possible to check that all patients were assessed within 15 minutes as the newly introduced computer system did not yet collect the required information. Triage was usually carried out by minor injury practitioners or emergency nurse practitioners. At Newton Abbott it was often carried out by an assistant practitioner or a healthcare assistant. They had received additional training in triage techniques. We were shown competency assessment documents which demonstrated that they had achieved the same competency levels as qualified nurses.

- The triage screen of the computer system consisted of a 'decision tree' which aided triage decision making. As information was entered, it prompted other questions to be asked and additional information to be gathered. This helped to ensure that all risks to the patients were addressed.
- We observed the triage of two patients, with their consent. The process was carried out in a thorough, effective and sympathetic manner.
- The scope of practice for the MIUs did not include the treatment of illness in children under two. However, all children were clinically assessed by nurses who had been trained to assess children. Clinical protocols then determined where the child should be treated. Direct referrals to other clinicians were made if appropriate.
- The national early warning score (NEWS) was used to identify patients whose condition was at risk of deteriorating. Points were allocated to a patient's vital signs such as heart rate, temperature and blood pressure. The points were added up to achieve a total score which then determined priorities for further action. There was a similar system tailored for the needs of children. The score was calculated by the computer although we noted that the appropriate screen was sometimes difficult to find.
- The aim of the units was to treat minor injuries but staff had recognised that people will sometimes attend with serious clinical conditions. As a result, staff had received specific training in the recognition of a deteriorating patient. There were clinical protocols for the recognition of a sick adult, sick child, and life threatening conditions such as peri-arrest situations and sepsis.
- Patients who were seriously ill or injured were transferred by ambulance to the emergency department at Torbay hospital according to local protocols
- During our review of records we found that the protocols had been followed. For example, someone who had fallen from a height onto a hard surface was found to have symptoms of chest trauma and internal injuries. An ambulance was called and the patient was transferred to the emergency department within an hour.

Nursing staffing

- A review of staff rotas for January 2016 showed that all MIUs had a minimum of one nurse practitioner or minor injury practitioner on duty at all times. Newton Abbott, the largest of the units, had at least two practitioners present at all times. This was so that there was always peer support available for other units where only one practitioner was present.
- At Newton Abbott nurse practitioners were supported by an assistant practitioner and two healthcare assistants.
- There were two part-time nursing vacancies, one due to long-term sick leave. Most of the shifts had been filled with existing staff but two temporary practitioners had also been used. We were shown the induction checklist for temporary staff and were told that they would not work on their own until they were familiar with local working practices. The addition of temporary staff meant that there had been no un-filled shifts in the previous month.
- The consultant nurse told us that, in the past, it had been difficult to find nurse practitioners at short notice. As a result, she now had an arrangement with two local nursing agencies so that they would send her the qualifications of any practitioner who applied to them. In this way the qualifications could be checked in advance to make sure that they were suitable for a MIU.
- Flexibility of nurse staffing meant that here had only been three occasions when an MIU had to close in the last year (due to staff sickness). Brixham had closed for one day and Totnes for two half days. Neighbouring services such as local GPs and out-of-hours services had been informed when this happened.
- There were no qualified children's nurses in the MIUs but there was a lead nurse for children, based at Newton

Good

Are services safe?

Abbot. She worked closely with the trust's paediatric liaison nurse and visited each unit at least monthly. Children under two years of age were not treated at the units. However, all nurse practitioners had been trained to assess children and to decide which services would best meet their needs.

- There was no lone working in any of the units. There was always a receptionist on duty should nursing staff need to call for help.

Major incident awareness and training

- The MIUs had recently become part of the trust's response to major incidents. They formed part of the 'Bronze 3' receiving units which meant the ambulance service would bring people with minor injuries to be treated.
- There had recently been a training exercise and there were arrangements in place to call in extra staff from home if necessary.
- All the MIUs had emergency call bells should staff need to summon assistance.

Good

Are services effective?

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

Summary

We rated urgent care in minor injuries units good for effectiveness because:

- Pain relief was administered quickly and effectively.
- Evidence based guidelines and protocols were easily available. Their use was monitored monthly to ensure consistency of practice.
- There were regular clinical audits and the results of these were shared with, and understood by, staff in all the units. The information gained was used to improve care and treatment.
- Each member of staff maintained a competency portfolio and additional learning needs were identified at annual appraisals.
- Staff were well qualified and demonstrated the skills that were required to carry out their roles effectively and according to best practice. They worked collaboratively with multidisciplinary teams from community services and acute services at Torbay hospital.
- Staff had a sound knowledge of consent from children and adults.
- Protocols for assessing mental capacity were immediately available via the computer system and their application was well understood.

Evidence-based care and treatment

- There was a comprehensive set of treatment guidelines based on guidance from the National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM). They included topics such as lower limb fractures and animal bites.
- Staff were familiar with their use and they were easily available on the computer system. Any changes were discussed at governance meetings and updated as necessary.
- Monthly audits helped to ensure that they were being followed. Results showed good compliance.

Pain relief

- Patient records showed that a pain score was always calculated and recorded. Appropriate pain relief was given and the effects monitored.
- The computerised triage protocols meant that a patient's assessment could not be completed until pain had been assessed.
- During our inspection we observed timely pain relief administered to children. The results of the pain relief were monitored and additional treatment given if necessary.

Nutrition and hydration

- 95% of people spent less than 40 minutes in the MIUs and so food was not provided. Staff could make drinks for people if appropriate.
- Drinks and snacks were available from cafeterias or vending machines. People that we spoke with said that they were easy to find and of good quality.

Patient outcomes

- There were monthly audits of compliance with clinical protocols, the appropriateness of X-ray requests and medicines management. These demonstrated that, although there had been good compliance with evidence based practice at the beginning of 2015, it had improved throughout the year. For example, an audit dated 1 February 2016 from one of the units, showed 100% compliance with evidence based practice. Examples of practice that had been reviewed included relevant examination as per protocol, appropriate and effective pain relief, clear diagnosis, appropriate treatment plan, and comprehensive discharge information. If weaknesses were revealed, staff would be given additional support or training. This helped to ensure that the intended methods of diagnosis and treatment were being achieved.
- There were no national audits specific to minor injuries but the service was taking part in a national survey of injuries sustained as a result of violent assaults.
- A low rate of unplanned re-attendances within seven days is often used as an indicator of good patient outcomes. At the beginning of 2015 it had been recognised that some units had a re-attendance rate that was higher than expected. For example, in April 2015 at Dawlish it was 18% although at Newton Abbot it was only 5.1%. The national average is 7.5%. Analysis of

the re-attendances and further staff training resulted in a reduction. By January 2016 all units were better than the national average. Dawlish had reduced its unplanned re-attendance rate to 0.6% and the highest, Paignton, was only 2.9%.

Competent staff

- Staff who were new to the department took part in a structured orientation programme. Staff that we spoke with told us that they found it informative and effective.
- The orientation programme for nurse practitioners lasted for a minimum of four weeks and practice during this time was always supervised.
- Each practitioner completed a competency portfolio containing skills such as the diagnosis and treatment of head injuries, animal bites, burns, and minor fractures.
- There were monthly group clinical supervision sessions where staff could discuss any difficulties that they might have experienced. One to one clinical supervision was available if staff preferred.
- Specific learning needs for all staff were identified at a yearly appraisal meeting. Records showed that all staff had received an appraisal in the last year.
- Professional competencies formed part of each person's job description. It was necessary to reach a certain level of competency before being promoted to a more senior position.
- There were close links with the University of Plymouth and staff had obtained qualifications as assistant practitioners and emergency nurse practitioners.
- In-house teaching was run by senior staff and included topics such as removal of foreign bodies, shoulder injuries, lower limb fractures and the treatment of burns.
- It had been recognised that some injuries were more common at some units than others. For instance there were more eye injuries at Dawlish and more childhood injuries at Newton Abbott. Staff regularly rotated between the units in order to maintain their skills in all clinical disciplines.

Multidisciplinary working

- There were good working relationships with community services and with Torbay hospital.
- If patients needed urgent hospital treatment they could be referred directly to specialist doctors such as orthopaedic surgeons, burns specialists, rheumatologists, and dermatologists.
- Practitioners could discuss complicated injuries or X-rays with a senior doctor at Torbay emergency department.
- Direct referrals could be made to physiotherapists for conditions such as soft tissue injuries or ligament strains. We were told that the physiotherapists encouraged children's referrals to prevent long-term conditions arising in adulthood.
- Letters were sent to GPs after each attendance. We reviewed ten letters and found clear and comprehensive descriptions of diagnosis, treatment, and advice was recorded in all.
- There were effective links with other services such as health visitors, sexual health clinics, district nurses, and social services.
- At Paignton we were told about an elderly patient who had sustained a fracture and could no longer use walking aids that maintained their mobility at home. A referral to social services and the district nurses resulted in effective support arrangements within 24 hours. This meant that the patient was able to go home rather than be admitted to hospital.
- Urgent appointments could be made with local GPs for children under two years or with acute conditions that were not minor injuries.

Seven-day services

- All the MIUs were open seven days a week except for Paignton which opened from Monday to Friday and from 8am to 5pm.
- The consultant nurse told us that the opening hours for each unit had originally been agreed with local authorities and the wider community. Discussions had recently started with the aim of standardising the opening times of all units.
- There had only been three occasions when an MIU had to close in the last year (due to staff sickness). Brixham had closed for one day and Totnes for two half days. There were protocols to follow when this occurred such as informing the 111 service, local GPs and out-of-hours services.

Access to information

- Information needed to deliver effective care and treatment was well organised and accessible. Treatment protocols and clinical guidelines were computer based and we observed staff referring to them when necessary.

Good

Are services effective?

- The computer system was shared with other MIUs and the emergency department so that previous records could easily be accessed.
- Previous X-rays and their results were always available via computer.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed that consent was obtained for any procedures undertaken by the staff. This included both written and verbal consent.
- Consent forms were available for people with parental responsibility to consent on behalf of children. The nursing staff that we spoke with had a good working knowledge of the guidance for gaining valid informed consent from a child. They were aware of the legal guidelines, which meant children under the age of 16 were able to give their own consent if they demonstrated sufficient maturity and intelligence to do so (often called Gillick competant). Otherwise, consent would be sought from the child's parent or guardian. If a child attended without a person who was able to provide consent, staff would attempt to contact an appropriate adult.
- The staff we spoke with had sound knowledge about consent and mental capacity. Protocols for assessing mental capacity were immediately available via the computer system.
- Staff were able to access acute mental health services if necessary. For example, a patient with a deliberate self-harm injury could be referred to the psychiatric crisis team. Staff told us that they generally responded within two hours. If a patient did not want to wait MIU staff would carry out a mental capacity assessment to determine whether they had capacity to refuse treatment. If someone did not have mental capacity, a GP would be contacted with a view to treatment under a section of the mental health act.

Outstanding ☆

Are services caring?

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

Summary

We have rated urgent care services as outstanding for caring because:

- Feedback from patients and those close to them was continually positive regarding the way they were treated. The care that they received exceeded their expectations.
- We observed staff taking trouble to maintain people's privacy, dignity and confidentiality. They demonstrated empathy towards people who were in pain or distressed and were skilled in providing reassurance and comfort.
- People were kept informed and given information about their condition and their care and treatment. Their social and emotional needs were highly valued by staff and were embedded in their care and treatment.
- Patients were assisted to maintain their independence whenever possible.
- Communication with children and young people was age appropriate, effective and often humorous. This helped to reduce the distress that children frequently feel when they are injured.

Compassionate care

- Confidentiality was maintained at most of the reception desks by means of signs asking people to stand back from the desk when someone was being registered. The exception was Paignton. We raised this with a senior member of staff who told us that a notice would be displayed as soon as possible.
- The majority of units had single rooms with doors to ensure privacy when patients were being examined. We saw that staff knocked and waited to be called before entering. At Totnes, there were curtains around two cubicles which mean that confidential information could have been overheard. Staff told us that there would only be two patients present in an emergency. A business case was being compiled in order to purchase a sound-attenuated screen to improve privacy.
- We observed staff introduce themselves and explain what was about to happen before examining patients.
- We saw many examples of patients being treated with compassion, dignity and respect. Staff spoke in a respectful but friendly manner and made allowances when people were stressed or worried. We observed a nurse putting their arm around a patient's shoulders when they became upset about the length of treatment that was needed for their injury.
- Nurses took time to distract and comfort children during injections and wound cleaning. Parents were involved in the assessment and treatment of their children and clear explanations were given.
- We spoke with eleven patients and two family members. They all reported a positive experience. One said "I think they're all marvellous". Another told us "They've been fantastic".
- We were shown letters of appreciation from patients. One said "I was amazed to find that the Totnes MIU was open from 8am to 9pm. I was most impressed with the excellent treatment and follow up I received."
- Results from the Friends and Family test for the year ending December 2015 were consistently good. They showed that between 97% and 100% of people would recommend the Minor Injuries Units (MIUs).

Understanding and involvement of patients and those close to them

- Patients and their families told us they were kept informed of all care and treatment due to be carried out. Staff were praised for the quality of the communications to families so that they understood the sequence of events and the likely timings around these. We spoke with the father of a large family who told us that he had attended Paignton on several occasions. He said "Every time I have been here, they've been wonderful."
- We spoke with three patients as they left the unit. They had all been given advice about what to do when they were at home. Two had been given information leaflets to reinforce the verbal advice.
- At Totnes, a patient had been incorrectly referred to the MIU for review of a previous fracture and a change of plaster cast. A receptionist asked the nurse practitioner for advice. Rather than simply re-direct the patient the nurse practitioner asked for her to be booked in so that

Are services caring?

he could explain in detail why another hospital was the most appropriate place. The patient did not leave until an orthopaedic appointment had been made and staff were sure that the limb was comfortable.

- A patient, who was waiting for an X-ray at Totnes, told us "They have explained what is going on and have given me painkillers. They have all been very polite and helpful."

Emotional support

- Communication with children was thoughtful and age appropriate. We observed a receptionist making a joke when she registered a child. This put the child and parents at ease and turned tears to smiles.
- A patient at Newton Abbott had sustained a complicated fracture that needed specialist treatment at Torbay hospital. She was worried that she could not go to work and did not have the number with her to contact her employers. A member of staff found the number via the internet and contacted the company on the patient's behalf. On his return he passed on their good wishes and the fact that an absence from work was not a problem. The patient was visibly relieved and reassured.
- A letter from a patient who had attended Brixham MIU whilst on holiday said "Your reassurance and care was much appreciated by us both at a very anxious time."
- The mother of a child being treated at Newton Abbot told us that social and emotional needs were always considered. She said that the complexities of looking after a family with small children had always been taken into account whenever she had attended.
- Staff were aware of local counselling services and would refer patients when appropriate.

Good

Are services responsive to people's needs?

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

Summary

We rated urgent care services as good for responsiveness because:

- Services were planned to meet the needs of all patients, including those who were vulnerable or who had complex needs.
- The units were easy to access and there was sufficient space for the number of people using them
- 99.8% of patients were treated, discharged or transferred within four hours during 2015. This was as good as, or slightly better than, most other minor injury services.
- The average time to treatment was 23 minutes. Waiting times were constantly monitored in real time via the shared computer system.
- If one particular unit was experiencing increasing delays staff could be transferred from quieter units to provide help.
- The needs of people with complex needs were well understood and addressed appropriately. People with dementia or learning disabilities received care and treatment that was sympathetic and knowledgeable.
- Improvements were made to the quality of care as a result of complaints and concerns.

However;

- X-ray services were not always available when patients needed them. There were no X-ray services at weekends which meant that patients had to go to the emergency department at Torbay if a fracture was suspected

Service planning and delivery to meet the needs of local people

- Most of the minor injury units were well signposted and easy to access. All had drop-off points close to the front door for people with mobility difficulties. We experienced difficulties finding Paignton MIU and there were no parking spaces in the hospital grounds. However, local people that we spoke with said that they knew where to find the hospital and also where parking could be found in nearby streets.
- There were X-ray facilities in each community hospital but they were not always available when MIU patients needed them. At Totnes the X-ray department was only open two mornings a week. At Brixham the department is open for three whole days and two half days. At Paignton, X-rays are only available in the afternoons. There were no X-ray services at weekends.
- Patients who had suspected fractures when the X-ray department was closed had to be referred to another MIU or to the emergency department at Torbay.
- Waiting rooms had sufficient space for the patients using them and all had useful health information posters and leaflets. For instance there was information about the signs of sepsis, how to recognise someone is having a stroke and support for victims of domestic violence.
- Patients told us that they appreciated the short waiting times in comparison to local accident and emergency departments.
- Torbay and South Devon had been selected by NHS England to become one of eight urgent and emergency care vanguards which are aimed at improving the coordination of urgent and emergency care services. Planning had started to expand the MIU services at Newton Abbot so that minor illnesses could also be treated. There was a possibility of developing an urgent care centre adjacent to the emergency department at Torbay hospital.

Meeting people's individual needs

- Staff that we spoke with demonstrated a good understanding of the requirements of patients with complex needs. There were close links with community services to provide support.
- The majority of staff had undertaken training in the specific needs of people with dementia and learning disabilities and the involvement of families was encouraged. The appointment of a trust-wide learning disabilities team had improved awareness and staff felt able to contact them for advice. The computer system featured a flagging system for people with learning disabilities so that staff could be alerted to their special needs.

Good

Are services responsive to people's needs?

- We observed a patient living with dementia being given extra time during treatment to enable them to understand what was happening. Clear and simple explanations were given and calmly repeated in order to reassure the patient.
- We observed the treatment of a patient with learning disabilities. Care was provided in a quiet part of the unit so that their exposure to the unfamiliar and confusing environment of a hospital was kept to a minimum. Their particular needs were carefully discussed with them and their carers and treatment was provided accordingly.
- X-ray departments at the community hospitals would not accept requests for hip X-rays from the MIUs. Patients with suspected broken hips had to be transferred by ambulance to the emergency department at Torbay.
- Translators could be accessed via the telephone translation system provided by the hospital. In addition there were posters in many different languages informing people of community based translation services.
- Patients told us that they appreciated the local knowledge of the staff in the MIUs. One said "I come here to get advice. They always seem to know what to do and where to go."

Access and flow

- All the MIUs were clearly signposted and easy to find from the main entrance of each hospital.
- The trust consistently exceeded the national standard which requires that 95% of patients are discharged, admitted or transferred within four hours of arrival at MIUs. Annual performance for the year ending December 2015 was 99.8%, with 97% spending less than two hours in the units.
- While waiting no more than four hours from arrival to departure is a key measure of MIU performance, there are other important indicators, such as how long patients wait for their treatment to begin. A short wait will reduce patient risk and discomfort. The national target is a wait of below 60 minutes. The trust consistently achieved this target. The average time to treatment in 2015 was 23 minutes. 95% of patients spent no more than 39 minutes in an MIU in total.
- The consultant nurse monitored waiting times in each MIU at regular points throughout the day. If delays were increasing at one unit it was often possible to move a member of staff from another unit to help.
- The percentage of patients who leave without being seen is often used as an indicator of the responsiveness of a unit. The lower the percentage the better. An average of 0.9% of patients left without being seen in 2015. This compared well to emergency departments where the average in England was 2.5%. Figures for all of the MIUs were similar.

Learning from complaints and concerns

- There had been few complaints in the last year but those that had been received were handled in line with the trust policy. If a patient or relative wanted to make an informal complaint they were directed to the nurse in charge of the department. If the concern was not able to be resolved locally, patients were referred to the Feedback and Engagement team that would formally log their complaint and attempt to resolve their issue within a set period of time. Information about the Feedback and Engagement team was displayed on noticeboards in all the units and was included in patient information leaflets.
- Formal complaints were investigated by senior MIU staff and people were often invited to come to meet with a senior member of staff to discuss their concerns. Replies were sent to the complainant in an agreed timeframe. The two replies that we saw were detailed and courteous. Where possible, action was taken to prevent similar complaints. For example, there were now information displays about what happens in MIUs and why there may be occasional delays. This helped people to understand why they may have to wait to be treated.
- We saw that learning from complaints was discussed at governance meetings and team meetings.

Good

Are services well-led?

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

Summary

We rated urgent care services as good for well led because:

- The minor injury units had an effective and cohesive leadership team who identified with a strategy of delivering more care and treatment in a community setting. They were knowledgeable about quality issues and priorities, understood what the challenges were and took action to address them.
- There was a strong sense of teamwork between all staff, irrespective of the unit in which they were based. There were shared values of delivering high quality patient care. Mechanisms were in place to support staff and promote well-being.
- Governance arrangements were well structured with risks and quality being regularly monitored and action taken if necessary. The Quality, Safety and Effectiveness Trigger Tool provided consistency and ensured that performance and quality in the minor injury units were understood by senior trust managers.
- Community stakeholder meetings were currently taking place in order to better understand the type of urgent and emergency care that local people would like.

Vision and strategy for this service

- The inclusion in one of NHS England's urgent and emergency care vanguards was determining future strategy. Discussions were taking place with NHS commissioners about the best way to improve the co-ordination of all emergency and urgent care services in the locality. The consultant nurse was part of the task and purpose group which was exploring the role of MIUs within the vanguard. It was anticipated that there would be a public consultation later in the year.
- Staff were updated on the progress of discussions during team meetings. They identified with the aims of the strategy to deliver more treatment and care in a community setting.
- The consultant nurse emphasised the importance that senior staff placed on collaborative working with support services ranging from X-ray to social services.

Governance, risk management and quality measurement

- Governance was led by a senior member of staff but many staff that we spoke with felt that they shared the responsibility for delivering safe and high quality services.
- Regular risk assessments took place and mitigating action was taken to reduce risks to patients and staff. For example, the risk of aggression or violence towards staff at Totnes had been mitigated by installing CCTV in the waiting room, locking of doors out-of-hours and use of personal safety alarms.
- Risks were reviewed at least quarterly but more often if needed. Any high risk issues were incorporated into the relevant hospital risk register. No risks had been rated as high at the time of our inspection.
- The Minor Injuries Units (MIUs) contributed to the community hospitals Quality, Safety and Effectiveness Trigger Tool (QuESTT).Examples of triggers that were monitored monthly included staff vacancy rates, patient waiting times, complaints trends and patient feedback. Reports from the previous 12 months showed that quality was good in all the MIUs. Staff told us that QuESTT reports were reviewed monthly by the Trust Board.
- Incidents and complaints were reviewed monthly in order to identify trends and to take action if necessary.

Leadership of service

- Managerial and clinical leadership of the MIUs was provided by a consultant nurse who in turn reported to the assistant director of community hospitals. Each MIU was led by a band 7 sister or charge nurse.
- The consultant nurse spent time at all the MIUs and took an active role in the treatment of patients. Staff told us that she had the knowledge, skills and capability required to lead the service.
- Staff told us that they trusted the leadership team and knew that they would be listened to if they raised concerns. They told us that there was a 'no blame' culture that made it easier to admit mistakes and to learn from them.
- Community hospitals and services had amalgamated with Torbay hospital in October 2015. There had been a number of senior management changes as a result and

Good

Are services well-led?

staff were kept abreast of these changes at monthly team meetings. Staff that we spoke with were aware of the visits that the chief executive officer had made to the MIUs.

Culture within the service

- Staff told us that they felt respected and valued by their colleagues and the leadership team within the MIUs.
- Although each team was proud of the MIU in which they were based, there was an appreciation of the needs of the other units. There was a great deal of flexibility amongst staff and they were always willing to help other units when needed.
- The culture within all the MIUs was centred on the needs and experience of people who used the service. Several staff told us "It's the patient who's important".

Public engagement

- Stakeholder meetings were currently being held throughout Torbay and South Devon to understand the type of urgent and emergency care that people would like. Meetings included GPs and local councillors.
- The service was currently taking part in a national survey of injuries sustained as a result of violent assaults. It was aimed at identifying "hotspots" in the community so that crime prevention measures could become more focussed.
- The consultant nurse kept copies of patient feedback and letters of comment or complaint. She told us that there were many more compliments than complaints.
- In 2015, the service took part in a quality project aimed at improving the uptake of drug and alcohol services. All adult patients were given questionnaires and information leaflets explaining the nature of the project. Staff told us that only three patients engaged with drug and alcohol services, over and above those who had been referred by staff. This confirmed that existing referral practices were appropriate.

Staff engagement

- Monthly team meetings were rotated between different units to enable easy access for as many staff as possible. Discussions were held about changes in the trust and options for the future direction of the MIUs.
- A member of staff described the support that was given during a long illness and a graduated return to work.
- Debrief sessions were held by senior staff after difficult clinical situations.
- At the end of 2014 the MIU service won a 'Blue Shield award' from the trust for outstanding contribution to health and social care in Torbay and South Devon.

Innovation, improvement and sustainability

- The implementation of a computer system used by all MIUs and the emergency department at Torbay meant better access to patient records and enabled the activity of all the units to be monitored in real time. This was unusual and allowed staff to be more responsive to patients in each unit.
- A trauma triage system had been introduced which reduced the need for long journeys for people who had sustained fractures. Clinical notes and X-rays were viewed electronically by an orthopaedic consultant in Torbay. Following this review many patients could continue their treatment at their local minor injury unit. Only people with more complicated fractures were asked to travel to Torquay for specialist treatment.