Torbay and South Devon NHS Foundation Trust

Torbay Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Requires improvement
Urgent and emergency services	Good
Medical care (including older people's care)	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Torbay and South Devon NHS Foundation Trust is an integrated organisation providing acute healthcare services from Torbay Hospital, as well community health services and adult social care. The trust's acute hospital services are run from Torbay Hospital in Torquay. The trust serves a resident population of approximately 375,000, increasing by up to 100,000 at any time during the summer holiday season.

We previously inspected Torbay Hospital in February 2016 and rated the hospital as requires improvement overall. Following that inspection we rated urgent and emergency care as inadequate, and medical care (including older people's care) as requires improvement.

This inspection was unannounced and took place in May 2017. We inspected emergency and urgent care, and medical care (including older people's care) to review progress made to improve these core services.

We found all the requirement notices issued following our previous inspection for both emergency and urgent care and medical care (including older people's care) had been met. We found significant improvements had been made in both core services.

Our key findings were as follows:

Safe:

- We rated both core services inspected as requires improvement for safe.
- Confidential patient records were not always stored securely, leaving them potentially subject to unauthorised access.
- Completion of safeguarding training often fell below trust targets, which meant staff may not have had the most up-to-date knowledge in order to keep vulnerable people safe.
- Processes for managing medicines and Patient Group Directions (PGDs) were not always effective. Some medicines were found to be out-of-date, refrigerator temperatures were not always regularly monitored and PGDs were not always signed.
- We found two fire escape routes on two different wards were cluttered, posing a risk in the event people were required to evacuate the hospital.
- A significant amount of equipment had no evidence of regular servicing, which meant there was a risk these items could fail or not function correctly.
- Regular auditing of record-keeping was not always completed.
- There was a positive incident reporting and learning culture. When things went wrong staff were encouraged and felt able to report incidents. Incident investigations were used as opportunities to learn and improve services.
- Staffing levels had been reviewed using national tools and the numbers of staff on duty kept people safe most of the time. Consultant cover had been reviewed and changes to rotas had improved availability of consultants.

Effective:

- We rated both core services as good for effective.
- Protocols and pathways were evidence-based and followed national guidelines. Compliance with these was regularly audited and areas for improvement were identified and developed.
- Multidisciplinary working had improved and was working well across the two core services.
- Staff had a good understanding of the Mental Capacity Act 2005, including consent.
- Regular training opportunities were made available to staff to ensure they were competent to carry out their roles.
- Discharge summaries were not completed consistently, which meant other healthcare professionals, for example GPs, were not always aware of their patient's full medical history and ongoing plans.

Caring:

Summary of findings

- We rated both core services as good for caring.
- Feedback we received from patients and relatives was consistently positive.
- Patients and their relatives were treated with compassion, involved in discussions about their care and treated by staff with dignity and respect.
- A small number of patients reported delays in staff responding to call bells.

Responsive:

- We rated both core services as good for responsive.
- Patient flow through the hospital had been improved and weekend discharges increased. Work was ongoing with partners and stakeholders to identify further strategies that could help improve patient flow.
- The trust's escalation process for responding to severe pressures and increased demand had been overhauled and provided much improved communication and joint working across the healthcare system.
- Complaints were responded to promptly and areas for improvement identified within investigations.
- Performance against national standards was consistently high. For example, the trust performed better than the England average for the numbers of patients discharged, admitted or transferred from the emergency department within four hours (although this was slightly below the standard of 95%).
- The emergency department had taken limited steps to support patients living with dementia.
- A lack of space in the emergency department prevented patients who were waiting in the corridor from receiving adequate privacy.

Well-led:

- We rated both core services as good for well-led.
- The improvements that had been delivered were testament to the leadership and staff engagement.
- Improvement plans and strategies had been developed with staff and were focused on delivering high-quality care.
- Strong governance processes were in place and these helped drive improvement. Risks were understood, regularly discussed and actions put in place to reduce the risks where possible.
- Staff spoke of an open, supportive culture and felt able to raise concerns with the leadership teams.
- Mortality and morbidity reviews did not always take place regularly.
- Some staff felt divisional leaders were not visible at service level.

We saw some areas of outstanding practice, including:

- The trust had fully addressed the requirement notices from our inspection in February 2016. In particular we saw significant improvements had been made in the emergency department in terms of safety, quality, performance and patient experience. The department had streamlined processes and introduced a system of triage and rapid assessment, which improved safety, efficiency and patient flow.
- We saw exceptional multidisciplinary working between the whole healthcare system in response to the trust's escalation process
- A newly created mental health assessment room provided a safe, welcoming and calming environment, located away from the hustle and bustle of the busy emergency department.
- There was a separate children's area in the emergency department, which was secure and was not overlooked by adult patients and visitors. This area was staffed by a dedicated trained paediatric nurse workforce. In addition, adult trained nurses received paediatric training as part of their induction and mandatory training.
- There were cooperative and supportive relationships amongst staff in the emergency department. We observed excellent teamwork, particularly when the department was under pressure.
- Service improvement was everybody's responsibility in the emergency department. Staff had been engaged in the improvement journey and had been encouraged to participate in service design and to make suggestions for improvement.

Summary of findings

- There was a great sense of pride amongst staff in the emergency department. They contrasted their feelings of despondency at the time of our previous inspection, with feelings of pride and optimism in the present.

However, there were also areas where the trust needed to make improvements.

Importantly, the trust must:

- Ensure the secure storage of confidential patient records in all areas.
- Ensure all medical equipment in the emergency department is serviced in accordance with service schedules.

In addition the trust should:

- Ensure signatures on nursing, medical and prescription records are legible.
- Ensure risk assessments are consistently completed.
- Ensure resuscitation trolleys and emergency equipment are checked daily across all medical areas in line with trust policies.
- Ensure systems aimed at ensuring the safety of medicines are effective, for example the checking of refrigerator temperatures and expiry dates.
- Consider how staff can be better included in consultation processes where service changes may affect them.
- Ensure mandatory training targets, including adult and child safeguarding, are consistently met.
- Ensure fire escape routes are kept free from clutter and obstructions.
- Ensure all staff comply with minimum training attainment levels.
- Ensure appraisals for nurses are completed.
- Ensure that regular mortality and morbidity meetings take place and related issues are included in emergency department clinical governance meetings.
- Ensure that appropriate and regular audit takes place.
- Ensure staff to patient ratios in the emergency department are appropriate to keep patients safe at all times.
- Ensure that intentional rounding frequency where critical observatuions are noted follow guidelines for all patients.
- Ensure patient confidentiality and privacy is protected in the emergency department.
- Ensure children waiting in the main waiting room of the emergency department are provided adequate privacy away from waiting adults.
- Ensure resuscitation trollies and equipment in the emergency department are readily available and kept clean.
- Ensure the emergency department sluice is secured and that flammable products are not accessible to unauthorised persons.
- Ensure Patient Group Directions used in the emergency department are signed by staff and counter-signed by managers.
- Provide training for emergency department receptionists to support the recognition of red flag presentations.
- Ensure access to major incident equipment in the emergency department is not obstructed.
- Ensure the bereavement (viewing) room in the emergency department Is an appropriate environment.
- Review the location and visibility of surgical waste bins that are visible from the emergency department relatives' room.
- Review the steps to support people in vulnerable circumstances, such as people living with dementia, or people with a learning disability are adequate.

Professor Edward Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Good 	We found the trust had addressed the requirement notices from our inspection in February 2016 and had made significant improvements in the effective, responsive and well-led domains. These three domains have changed from inadequate to good. Although there were also improvements in safe, we still had some concerns around the safety of the service. Safe has therefore changed from inadequate to requires improvement. We have rated this service as good overall because: • We saw significant sustained improvements had been made in the emergency department since our last inspection in terms of safety, quality, performance and patient experience and environment. • The department had streamlined processes and introduced a system of triage and rapid assessment, which improved patient safety, efficiency and patient flow. The department was working collaboratively with others to identify system-wide strategies to improve patient flow. • Physical improvements to the department included the creation of a triage pod in the main waiting area in minors, which enabled the triage nurse to view the waiting room. A secure children's department had been created, which was not overlooked by adult visitors, staffed by an appropriately qualified workforce. • A mental health assessment room had been created, which provided a safe and calming space for patients in mental health crisis. • Staffing had been increased with greater consultant presence in the department. The nursing staff establishment had also been increased to improve safety in the resuscitation area and to support the new triage and rapid assessment processes. A band seven nurse coordinator had been employed to manage patient flow and escalation. • Escalation processes had been improved and real time information was regularly shared with the bed management team and the rest of the hospital to improve shared ownership of patient flow.

Summary of findings

- There was a range of recognised treatment protocols and care pathways. Performance in national audits was mostly in line with other trusts nationally. There was evidence that audit was used to improve performance, for example in the treatment of sepsis.
- Nursing and medical staff told us they felt well supported with regular teaching.
- Care was delivered in a coordinated way with support from specialist teams and services, such as the stroke team.
- Feedback from patients and relatives was consistently positive. They told us staff were caring and compassionate, treated them with dignity and respect, and involved them in decisions.
- When patients experienced pain or discomfort, staff responded in a timely and appropriate way.
- Staff received training in the Mental Capacity Act 2005 and consent as part of their mandatory safeguarding training. Most staff demonstrated a good understanding of the legislation.
- Staff had easy access to relevant patient information which was updated as required.
- The trust was meeting the national standard and performed better than the England average in relation to the standard which requires that patients wait 60 minutes or less from their time of arrival to the time their treatment begins.
- People's complaints and concerns were listened to and responded to promptly. We saw evidence of learning and improvement following complaints.
- There was a detailed improvement plan in place with clear milestones and accountability for actions.
- There were effective governance arrangements in place. Risks were understood, regularly discussed and actions taken to mitigate them.
- There were cooperative and supportive relationships among staff. We observed excellent teamwork, particularly when the department was under pressure.
- Service improvement was everybody's responsibility. Staff had been engaged in the improvement journey and had been encouraged to participate in service re-design and make suggestions for improvement.

However:

Summary of findings

- Not all staff had received recent training on the major incident plan and not all medical staff were in date with safeguarding training or mandatory training overall.
- The emergency department was not designed to accommodate the number of patients who attended the department and sometimes there was not the physical space to accommodate all patients in a safe and appropriate environment.
- There was no formal audit relating to records standards, although five patient records were checked daily for evidence of intentional rounding.
- Mortality and morbidity meetings were not taking place regularly and the most recent clinical governance meetings for the emergency department held 14 March and 18 April 2017 did not include discussion regarding mortality and morbidity.
- An inventory and service history of all medical equipment showed there was a significant amount of essential equipment which had no records of service or where a service was overdue.
- Staffing levels in majors were planned to provide a registered nurse to patient ratio of between one to four and one to six. When all cubicles were full and patients queued in the corridor, staff were required to care for up to eight patients.
- There was limited waiting space in the children's department which meant some children had to wait in the main waiting room, overlooked by waiting adults.
- Patients who queued in the corridor were afforded little privacy.
- The unplanned emergency department re-attendance rate within seven days was generally worse than the England average and the national standard of 5%.
- Some patients spent too long in the emergency department because they were waiting for an inpatient bed to become available. Lack of patient flow within the hospital and in the wider community created a bottleneck in the emergency department, causing crowding.

Summary of findings

Medical care (including older people's care)

Good

We found the trust had addressed the requirement notices from our inspection in February 2016 and had made improvements in the effective, responsive and well-led domains. These three domains have changed from requires improvement to good. We still had some concerns around the safety of the service and this domain continues to be rated as requires improvement. Overall we rated medical care as good because:

- Recent reconfiguration of consultant working rotas had resulted in improved availability of senior physicians at the weekend.
- There was effective and consistent use of evidence based practices for patients in the medicine division.
- Multidisciplinary working was truly embedded throughout the division, both internally and externally to the hospital. This was particularly evident in the management of an OPEL four alert.
- Patients said staff were caring and compassionate, treated them with dignity and respect, and as an individual.
- Staff were skilled to be able to communicate well with patients and keep them informed of what was happening and involved in their care.
- Staff had knowledge of patients' circumstances and the impact their health had on them and their families.
- The division consistently met targets for senior review of acutely admitted patients both in and out of hours.
- A twice daily multidisciplinary meeting steered patient care and ensured actions were completed to advance diagnosis and treatment.
- The division worked closely with community based colleagues to ensure an efficient and safe step down process was in place for discharged patients.
- Emergency admissions units were used effectively to admit, and assess patients in a timely way and worked effectively with the emergency department.
- There was a focus on ensuring key messages from the governance team reached front line staff, and staff had a broad understanding of the direction of the medicine division.
- Staff felt connected to their line managers, able to raise concerns and make suggestions.
- A supportive and open culture was evident throughout the areas we visited.

However:

Summary of findings

- The environment on many of the medical inpatient wards was sub-optimal with cluttered conditions that could impact on the safety of vulnerable patients.
- Confidential patient records were not kept securely; records were stored on open shelves in the ward areas.
- Risk assessments were not always completed comprehensively, or signed legibly by nursing staff. Medical records and prescription charts were only signed legibly in two out of the 27 sets of records we looked at.
- Completion of safeguarding adults training at level three regularly fell below trust targets.
- Data collated showing the completion of discharge summaries demonstrated a poor performance against trust targets.
- Day rooms on the care of the elderly wards were not being used by patients. On Simpson ward the day room was very unappealing and sparse.
- Patients with dementia were not always cared for in line with national guidance from the Alzheimer's society. Performance against the dementia FIND targets fell substantially below expected levels.FIND targets describe the national requirement to find, assess and refer 90% of patients with dementia within 72 hours of admission.
- Staff felt poorly informed about the plans for acute bed closures and this caused anxiety and uncertainty in many staff we spoke with.

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Detailed findings

Services we looked at
Urgent and emergency services; Medical care (including older people's care)

Detailed findings

Contents

Background to Torbay Hospital

Torbay and South Devon NHS Foundation Trust provides a number of services across South Devon, mainly but not exclusively within the Teignbridge, Torbay and South Hams district areas. The trust provides a service to a population of around 375,000 people, plus around 100,000 visitors at any one time during the summer holiday season. Acute services are provided at Torbay Hospital located in Torquay.

Torbay and South Devon NHS Foundation Trust was created on 1 October 2015 when South Devon Healthcare NHS Foundation Trust, that provided acute services at Torbay Hospital, merged with Torbay and Southern Devon Health and Care NHS Trust, that provided community health and social care services.

The demographic data for Torbay, Teignbridge and South Hams Local Authorities are all very similar, however Torbay is more deprived than Teignbridge and South Hams. In the 2015 English Indices of Deprivation, Torbay Local Authority was in the 15% most deprived areas in the country. Teignbridge and South Hams Local Authorities were both in the 45% least deprived areas in the country. 17% of the population in Torbay are under 16, 16% in Teignbridge and South Hams (all three lower than the England figure of 19%). The percentage of people aged 65 and over is 26% in South Hams and 25% in Torbay and Teignbridge (all three higher than the England figure of 17%). Approximately 98% of the population in all three Local Authorities are of white ethnicity (higher than the England figure of 85%). There is a lower percentage of Black, Asian and Minority Ethnic residents (3% Torbay, 2% Teignbridge and South Hams) when compared to the England figure (14%).

This inspection was unannounced and followed-up on concerns raised at our comprehensive inspection in February 2016 where we rated urgent and emergency care as inadequate, and medical care (including older people's care) as requires improvement.

We looked at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations.

The inspection team inspected two core services:

- Urgent and emergency care
- Medical care (including older people's care)

Our inspection team

Our inspection team was led by:

Daniel Thorogood, Inspection Manager, Care Quality Commission

The team included a second CQC inspection manager, four CQC inspectors and five specialist advisors including a consultant endocrinologist, emergency care doctor, occupational therapist, and two nurses.

Detailed findings

The team was also supported by analysts and an inspection planner.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about Torbay Hospital. These included the local commissioning group and NHS Improvement.

We carried out an unannounced inspection on 3 and 4 May 2017, and returned on 10 May 2017 for an interview with the Chief Executive.

We held drop-in sessions and spoke individually with a range of staff at the hospital, including nurses, junior doctors, consultants, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff, porters and maintenance staff.

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

Urgent and emergency services

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

Information about the service

Urgent and emergency care and treatment is provided at Torbay Hospital by the urgent care division. The emergency department operates 24 hours a day, seven days a week.

Torbay hospital provides services to a resident population of approximately 375,000 people, plus about 100,000 visitors at any one time during the summer holiday season. The emergency department saw 73,330 patients in 2016/17, of which approximately 18% were children (0 to 16 years).

Adult patients in the emergency department receive care and treatment in two main areas; minors and majors. Self-presenting patients with minor injury are assessed and treated in the minors' area. Patients with serious injury or illness, who usually arrive by ambulance, are seen and treated in the majors' area, which includes a resuscitation room and 18 cubicles and side rooms. The majors' area is accessed by a dedicated ambulance entrance.

There is a dedicated children's unit with a small separate waiting area.

The emergency department is a designated trauma unit and provides care for all but the most severely injured trauma patients, who would usually be taken by ambulance to the major trauma centre at Plymouth (Derriford Hospital), if their condition allowed them to travel directly. If not, they may be stabilised at Torbay Hospital and either treated or transferred as their condition dictates. The department is served by a helipad.

There is a clinical decision unit which accommodates eight seated patients. This area is for patients who do not require admission but who are awaiting results of diagnostic tests or for discharge arrangements to be put in place.

We visited the emergency department over two weekdays**.** This was an unannounced follow-up visit to review progress made by the trust since our last inspection in February 2016. Urgent and emergency services at that time were rated as inadequate overall, but caring was rated good.

We spoke with approximately 32 patients and relatives. We spoke with staff, including nurses, doctors, managers, therapists, support staff and ambulance staff. We observed care and treatment and reviewed six care records. We also received information from people who contacted us to tell us about their experiences. Prior to and following our inspection, we reviewed performance information about the trust and data provided by the trust.

Urgent and emergency services

Summary of findings

We found the trust had addressed the requirement notices from our inspection in February 2016 and had made significant improvements in the effective, responsive and well-led domains. These three domains have changed from inadequate to good. Although there were also improvements in safe, we still had some concerns around the safety of the service. Safe has therefore changed from inadequate to requires improvement.

We have rated this service as good overall because:

- We saw significant sustained improvements had been made in the emergency department since our last inspection in terms of safety, quality, performance and patient experience and environment.
- The department had streamlined processes and introduced a system of triage and rapid assessment, which improved patient safety, efficiency and patient flow. The department was working collaboratively with others to identify system-wide strategies to improve patient flow.
- Physical improvements to the department included the creation of a triage pod in the main waiting area in minors, which enabled the triage nurse to view the waiting room. A secure children's department had been created, which was not overlooked by adult visitors, staffed by an appropriately qualified workforce.
- A mental health assessment room had been created, which provided a safe and calming space for patients in mental health crisis.
- Staffing had been increased with greater consultant presence in the department. The nursing staff establishment had also been increased to improve safety in the resuscitation area and to support the new triage and rapid assessment processes. A band seven nurse coordinator had been employed to manage patient flow and escalation.
- Escalation processes had been improved and real time information was regularly shared with the bed management team and the rest of the hospital to improve shared ownership of patient flow.
- There was a range of recognised treatment protocols and care pathways. Performance in national audits was mostly in line with other trusts nationally. There was evidence that audit was used to improve performance, for example in the treatment of sepsis.
- Nursing and medical staff told us they felt well supported with regular teaching.
- Care was delivered in a coordinated way with support from specialist teams and services, such as the stroke team.
- Feedback from patients and relatives was consistently positive. They told us staff were caring and compassionate, treated them with dignity and respect, and involved them in decisions.
- When patients experienced pain or discomfort, staff responded in a timely and appropriate way.
- Staff received training in the Mental Capacity Act 2005 and consent as part of their mandatory safeguarding training. Most staff demonstrated a good understanding of the legislation.
- Staff had easy access to relevant patient information which was updated as required.
- The trust was meeting the national standard and performed better than the England average in relation to the standard which requires that patients wait 60 minutes or less from their time of arrival to the time their treatment begins.
- People's complaints and concerns were listened to and responded to promptly. We saw evidence of learning and improvement following complaints.
- There was a detailed improvement plan in place with clear milestones and accountability for actions.
- There were effective governance arrangements in place. Risks were understood, regularly discussed and actions taken to mitigate them.
- There were cooperative and supportive relationships among staff. We observed excellent teamwork, particularly when the department was under pressure.
- Service improvement was everybody's responsibility. Staff had been engaged in the improvement journey and had been encouraged to participate in service re-design and make suggestions for improvement.

However:

Urgent and emergency services

- The emergency department was not designed to accommodate the number of patients who attended the department and sometimes there was not the physical space to accommodate all patients in a safe and appropriate environment.
- There was no formal audit relating to records standards, although five patient records were checked daily for evidence of intentional rounding.
- An inventory and service history of all medical equipment showed there was a significant amount of essential equipment which had no records of service or where a service was overdue.
- Staffing levels in majors were planned to provide a registered nurse to patient ratio of between one to four and one to six. When all cubicles were full and patients queued in the corridor, staff were required to care for up to eight patients.
- There was limited waiting space in the children's department which meant some children had to wait in the main waiting room, overlooked by waiting adults.
- Patients who queued in the corridor were afforded little privacy.
- The unplanned emergency department re-attendance rate within seven days was generally worse than the England average and the national standard of 5%.
- Some patients spent too long in the emergency department because they were waiting for an inpatient bed to become available. Lack of patient flow within the hospital and in the wider community created a bottleneck in the emergency department, causing crowding.

Are urgent and emergency services safe?

Requires improvement

We found the requirement notices issued following our inspection in February 2016 had been met. We have changed the rating for safe from inadequate to requires improvement because we found some other areas of concern.

We have rated safe as requires improvement because:

- There was no formal audit relating to records standards, although five patient records were checked daily for evidence of intentional rounding. The matron told us that any learning needs identified would be discussed with the relevant staff member, although this did not form part of a regular recorded face to face meeting.
- Patient Group Directions (PGDs), which allowed some registered nurses to supply or administer certain medicines to a pre-defined group of patients, were not all signed by staff or counter-signed by managers.
- An inventory and service history of all medical equipment showed there was a significant amount of essential equipment which had no records of service or that service was overdue.
- Staffing levels in majors were planned to provide a registered nurse to patient ratio of between one to four and one to six. However, when all cubicles were full and patients queued in the corridor, staff were required to care for up to eight patients.
- There was limited waiting space for children, which meant some children had to wait in the main waiting room, overlooked by adults.

However:

- Risk assessments in respect of infection control, pressure ulcer prevention and safeguarding were completed.
- There was a dedicated trained paediatric nurse workforce. In addition, all adult trained nurses received paediatric training as part of their induction and mandatory training. Some nurses had completed a three day supernumerary rotation to work with registered children's nurses to gain further competencies.

Urgent and emergency services

- There were structured medical and nurse staff handovers at the start of each shift, led by the consultant in charge. The meeting was well attended and all staff were engaged.
- There was evidence of learning from serious incidents. Incidents were regularly discussed at governance meetings and learning was disseminated through safety briefings, ongoing education and targeted teaching.
- Patients were assessed promptly on arrival in the emergency department. From May 2016 to April 2017, the trust's weekly performance for median time to assessment ranged between 10 and 23 minutes for self-presenting patients and between one and two minutes for patients arriving by ambulance.
- Medicines, including controlled drugs, were appropriately stored in locked cupboards or refrigerators and suitable records were kept.
- Staffing had been reviewed using recognised acuity tools and safe staffing levels. Staff to patient ratios had been defined and increased since our last inspection. This included an increase in the nurse cover for the resuscitation area.
- The trust had recruited more consultants and reconfigured job plans to ensure greater senior presence. Consultant cover was now provided in two overlapping shifts: 8am to 4pm and 2pm to 10pm and there was a minimum of an ST4 (specialist registrar year three) or above, supported by a consultant on call.
- The main waiting room in minors had been reconfigured since our last inspection and the triage nurse could directly observe nearly all patients in the waiting room and be alert to any deterioration in a patient's condition.
- There was a separate children's area which was secure and not overlooked by adult patients or visitors.
- There were effective processes in place for the identification and management of adults and children at risk of abuse. Staff were aware of safeguarding policies and procedures.
- There was a trust major incident plan which had been reviewed January 2017.
- We found patients or relevant persons were informed about errors, kept up to date with investigations and apologies issued, in accordance with the duty of candour regulation.

Incidents

- Between March 2016 and February 2017 the trust reported no never events in emergency and urgent care. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- In accordance with the Serious Incident Framework 2015, the trust had originally reported seven serious incidents in urgent and emergency care which met the reporting criteria set by NHS England between March 2016 and February 2017. Of these, four were finally attributed to the emergency department. The most common type of incident reported was 'pressure ulcer meeting SI criteria' with four incidents (57%).
- The four serious incidents in the emergency department were:
  - March 2016: pressure ulcer acquired in the emergency department
  - March 2016: a patient with confusion, possibly due to an infection, was left unsupervised while using a bedpan. The patient fell from the trolley and sustained a serious head injury.
  - June 2016: pressure ulcer acquired in the emergency department
  - September 2016: failure to diagnose serious injury
- In response to each serious incident there had been a root cause analysis investigation. There was learning identified in all cases. We were told that refresher training had taken place in pressure ulcer prevention. A team champion had been identified and they were responsible for ongoing education of staff in this area, and for auditing compliance with safe systems. Root cause analysis learning showed a range of potential improvements. The improvements were addressed through action plans. The action plan to address occurrence of pressure ulcers acquired in the emergency department had been closed due to a successful reduction in the number of pressure ulcers. However, some issues on the action plan for falls were considered not to be achievable within the emergency department. For example, all patients at risk of falls being in sight at all times. A change of the layout of the department was being considered to achieve this.
- Staff told us they were encouraged to report incidents and they received feedback when they did so.
- Incidents were discussed at governance meetings and learning was disseminated via daily safety briefings. We

attended one safety briefing after the morning handover and witnessed a discussion about a recent incident. Items discussed at these briefings were recorded weekly and emailed to staff.

- The trust told us there were quarterly mortality and morbidity meetings in the emergency department where the care of patients who had complications or unexpected outcomes was reviewed. Key learning from these meetings was discussed in governance meetings and shared with staff via email, and through targeted teaching sessions at staff handovers. The trust told us that all deaths in ED were discussed at the trust's mortality group. However, we found the last local mortality and morbidity meeting had taken place in August 2016; the meeting scheduled for January was cancelled due to winter pressures and had been re-scheduled to take place in May 2017. The most recent clinical governance meetings for the emergency department held 14 March and 18 April 2017 did not include discussion regarding mortality and morbidity, which limited learning and potential improvement in care.

Duty of candour

- Staff were familiar with their responsibilities under the duty of candour regulation. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. We saw from investigation reports following serious incidents that patients had received apologies and been informed about errors or poor quality care.

Safety thermometer

- Safety thermometer data (data collected on a single day in each month and used to record patient harm) for the period February 2016 to February 2017 reported:
  - one new pressure ulcer
  - 15 falls
  - four catheter-acquired urinary tract infections

Cleanliness, infection control and hygiene

- There were systems in place to prevent and protect people from a healthcare-associated infection.
- There were appropriately sited hand wash basins and hand gel dispensers in the emergency department. We saw staff washing their hands and observing standard infection control precautions; however, we saw one staff member was wearing nail varnish contrary to trust policy. Staff wore appropriate protective clothing when required and observed the 'bare below the elbow' policy.
- Premises were tidy and visibly clean. We saw cleaning being carried out throughout our visit. We were told that one cleaner was available at night, although they were not a dedicated resource as they could be required to undertake deep cleans elsewhere in the hospital. Monthly hand hygiene audits took place and showed high levels of compliance with safe practice.
- There were side rooms where patients with infections could be isolated.
- Waste, including sharps, was appropriately segregated, labelled and disposed of.
- The trust's Infection Prevention & Control Report 2016/17 reported that the trust conducted departmental audits every two years and monitored action plans arising from these audits. Findings from the report were included on the emergency department risk register and some outstanding actions had been completed, for example increased cleaning.
- There were side rooms where infectious patients could be isolated.
- Staff received training in infection control. Most nursing staff and healthcare assistants were up-to-date with this training (87.55%). Although most medical staff were also up-to-date (72%), this was below the target of 85%.

Environment and equipment

- The emergency department was not designed to accommodate the number of patients who attended the department and there was frequently not enough physical space to accommodate all patients in a safe and appropriate environment.
- Patients frequently queued in the corridor. This, at times, made patient movements difficult. We frequently saw patients being wheeled through very confined spaces where there was a risk of collision. We saw one patient looking particularly anxious while being wheeled on a trolley through such a confined space. However, there were no injuries to patients or staff reported as a result of the confined space.
- Since our last inspection the department had taken steps to mitigate the risks associated with crowding through the introduction of more streamlined

processes. These are reported under 'Assessing and responding to patient risk'. Environmental improvements had also taken place to mitigate areas of risk identified at our last inspection. This included the creation of a separate, secure children's area, the reconfiguration of the waiting room to improve the observation of waiting patients, and the creation of a dedicated mental health assessment room.

- There was a separate children's area which was secure and not overlooked by adult patients or visitors. However, there was limited waiting space which meant some children had to wait in the main waiting room where they were overlooked by adults. This was not in accordance with design guidance set out in Health Building Note 15-01: Accident and emergency departments (April 2013), which recommends the children's waiting area "should be provided to maintain observation by staff but not allow patients or visitors within the adult area to view the children waiting." We saw children waiting while adults were in the same area.
- The main waiting room in minors had been reconfigured since our last visit and a 'triage pod' had been created so the triage nurse could observe patients in the waiting room and be alert to any deterioration in a patient's condition. However, the nurse could still not see two chairs in the waiting area without moving.
- There was a designated mental health assessment room, which was appropriately fitted and furnished in accordance with recommendations by the Royal College of Emergency Medicine and the Psychiatric Liaison Accreditation Scheme.
- The emergency department was suitably equipped, although on one occasion during our visit the department ran out of patient trollies. We noticed on occasions that equipment was stored in the ambulance entrance. Although this did not prevent access to the resuscitation area, the major incident cupboards were not easily or immediately accessible. Equipment we checked was mostly clean, accessible and well maintained. Consumable equipment and materials were in plentiful supply and they were appropriately and safely stored.
- We checked resuscitation equipment. We saw records to show that all resuscitation trollies were regularly checked. However, we found one trolley was dusty, which was a potential infection risk. We also found defibrillator pads were not stored on the trolley but on a shelf behind, which posed a risk of delayed access to emergency equipment and treatment.
- We could not be assured that all equipment was appropriately maintained and fit for purpose. The service history of all medical equipment was monitored centrally by the trust's facilities team. An inventory and service history provided to us by the trust showed there was a significant amount of equipment which had no records of service or the service was overdue. Items included digital thermometers, blood glucometers, nurse call system, bariatric patient hoist, patient monitors, pulse oximeters, portable suction units, patient ventilators, a height-adjustable couch, and ECG recorders. The trust assured us that no incidents had occurred relating to faulty equipment.
- The sluice in the majors area was unlocked in a corridor accessible to the public. The keypad access was not in use. The room contained an unlocked cabinet containing flammable products, including six pressurised cans of liquid gas. We told the senior nurse at the time and the room and cabinet were locked.

Medicines (includes medical gases and contrast media)

- Medicines were appropriately stored in locked cupboards or refrigerators. Records showed that refrigerator temperatures were regularly checked and they were correct at the time of our visit.
- Controlled drugs were appropriately stored and suitable records were kept. Controlled drugs are medicines which require extra checks and special storage arrangements because of their potential for misuse.
- Some emergency nurse practitioners (ENPs) were trained as non-medical prescribers so they could supply and administer certain medicines. There were also Patient Group Directions (PGDs) in place which allowed some registered nurses to supply or administer certain medicines to a pre-defined group of patients without them having to see a doctor.We checked records and found these agreements were up-to-date, although they were not always signed by staff or counter-signed by managers.

Urgent and emergency services

Records

- Patient records were mostly electronic, with a few proformas, such as the mental health risk assessment, completed on paper. Paper and electronic records were managed appropriately
- We looked at a sample of six patient records. They were clear and mostly complete. Risk assessments in respect of infection control, pressure ulcer prevention and safeguarding were completed. Observations of vital signs and early warning scores were correctly recorded.
- There were no formal audits undertaken, specifically relating to records standards. However, a sample of five patient records was checked each day to check for evidence of intentional rounding, that patients had a name band, and that they had been offered a friends and family test questionnaire. Data provided to us showed the frequency of rounding, presence of a name band and a friends and family test questionnaire being offered were met on all but four days in February 2017, two days in March and three days in April. The matron told us that any learning needs identified would be discussed with the relevant staff member, although this did not form part of a regular recorded face to face clinical supervision.

Safeguarding

- There were effective processes in place for the identification and management of adults and children at risk of abuse, including domestic violence and female genital mutilation. Staff understood their responsibilities and were aware of safeguarding policies and procedures. There were safeguarding leads in the emergency department for adults and children.
- There were prompts within the electronic patient record to complete safeguarding assessments.
- Staff received regular training in safeguarding adults and children. Training records showed:
  - 100% of medical staff were up-to-date with safeguarding adults training at level one and 82% at level two (this was below the trust's target of 90%).
  - 97% of registered nurses were up-to-date with safeguarding adults training at level one and 96% at level two. In addition, two nurses were trained at level three.
  - 88% of healthcare assistants were up-to-date with safeguarding adults training at level one and only 25% at level two (both being below the trust's target of 90%.
- The emergency department met the Safeguarding Children Standards produced by the Royal College of Emergency Medicine, which states level two training should include training in female genital mutilation.
- The patient records system identified previous child attendances so staff would be alerted to possible safeguarding issues.
- The emergency department had access to a senior paediatric opinion 24 hours a day for child welfare issues.
- All skull or long bone fractures in children under one year were discussed with a senior paediatric or emergency department doctor during their attendance.
- There was a 'safety net' to ensure that child safeguarding referral rates were appropriate. The children's safeguarding lead reviewed all child attendances twice weekly and fed back to staff. An annual audit of children's safeguarding took place and there was ongoing education to address areas for action identified through this audit.

Mandatory training

- Most emergency department staff were up-to-date with training in safe systems, processes and practices, although the trust's compliance target was not met in all subjects.
- There was an annual mandatory study day, which all staff were required to attend. This provided refresher training in a range of mandatory subjects, including safeguarding adults and children, fire safety and infection control.
- Completion of mandatory training in May 2017 for the emergency department was partially compliant against a target of 85% in the following subjects:
  - Conflict resolution 81.32%
  - Health and safety 84.62%
  - Information governance 89.01%
  - Manual handling 82.42%
- The following mandatory training subjects were compliant:
  - Fire training 88.64%
  - Infection control 87.55%
  - Equality and diversity 85.35%
  - Safeguarding adults level one 97.44%

  - Safeguarding children level two 97.43%
- Newly appointed staff in the emergency department received a comprehensive period of induction. New nursing staff were supernumerary for five weeks, spending a week in each area of the department, including the children's area.

Assessing and responding to patient risk

- At our previous inspection we were concerned that patients did not consistently receive prompt initial assessment (triage) on arrival in the emergency department. We were also concerned that not all patients were observed in the waiting room. At this inspection we found the department had taken positive steps to mitigate both of these identified risks.
- The emergency department had introduced a triage system to ensure patients were quickly assessed in order to identify or rule out serious or life-threatening conditions, and to stream patients to the appropriate clinician or area of the department. The system, known as ROSE (Rapid Observations and Symptom Evaluation), allocated each patient a triage score according to the severity of their condition, ranging from one (immediately life threatening) to five (not serious). All nursing staff who undertook this role were required to complete training and a period of supervised practice.
- There was a rapid assessment cubicle where patients who had arrived by ambulance were taken on arrival. This area was staffed by a consultant or senior doctor (day time only), a registered nurse and a healthcare assistant. An initial assessment was completed, including observation of vital signs, and any required diagnostic tests were arranged. When delays were encountered, patients were assessed by the nurse coordinator. This assessment included a set of observations if they had not been recorded by the ambulance crew in the last 15 minutes.
- We spoke with a number of ambulance crews who were waiting in the emergency department. They told us they had seen significant improvements since the introduction of the rapid assessment process. However, they told us they still experienced frequent handover delays. In March 2017 there were 128 handovers delayed by more than 30 minutes and in April 2017, there had been 115.
- Self-presenting patients were triaged by a registered nurse following registration at the reception desk. The registered nurse was supported by an appropriately trained healthcare assistant who carried out diagnostic tests as requested by the registered nurse. The triage nurse was able to observe most patients seated in the waiting area so they would be alert to any patients who appeared very unwell.
- Receptionists told us they used their judgement and experience to recognise a seriously unwell or injured patient who needed immediate clinical attention. There was no written guidance about 'red flag' symptoms or signs that would help staff understand the severity of conditions. Staff confirmed they had not received any training to recognise 'red flags' (for example pain in areas of the body indicating more serious illness elsewhere). They told us they summoned help either in person or by phone. The Royal College of Emergency Medicine Triage Position Statement states: "Some elements of the triage process, such as initial recognition of urgency, may be undertaken by an unregistered health worker, e.g. reception staff using clearly defined 'red flags' which identify urgency. For this reason, non-registered health care workers in emergency settings should have basic training in red flag presentations and how to call for immediate assistance…".
- The trust monitored its performance against the standard issued by the Royal College of Emergency Medicine, which recommends that patients are triaged within 15 minutes of arrival. In the 12 months from May 2016 to April 2017, the weekly median time to assessment ranged between 10 and 23 minutes for self-presenting patients and between one and two minutes for patients arriving by ambulance.
- There was a risk assessment tool used to establish the level of risk associated with patients presenting with mental health needs. The tool, produced by the local mental health trust who provided liaison psychiatry services, allowed staff to assess the risk that a patient presented to themselves or others and set out actions to take depending on the level of risk. Patients who were identified as at risk required close and frequent observation and urgent referral to the liaison psychiatry team or on call mental health team (out of hours).
- Risk assessments were carried for falls and pressure ulcers. We saw these were completed in the sample of records we checked.
- The emergency department used a recognised early warning tool used for adults and children. For adults the National Early Warning Score (NEWS) was used, and for

children they used the Paediatric Early Warning Score– (PEWS). We were told compliance with both these tools was audited; however, we were only supplied with evidence of the PEWS audit. The vital signs audit had limited analysis but showed the documenting of vital signs and the actions taken was being completed correctly.

- There were standing operating procedures in place which set out actions required in the event that the department became crowded. Crowding could occur either due to a sudden influx of patients or due to patient flow issues in the hospital leading to delays transferring patients from the emergency department. In the event that a patient's rapid assessment was delayed, a nursewas allocated to undertake a 'fast registration', including a first set of observations.
- There were two-hourly safety barometer checks conducted by the emergency department coordinator. This was an opportunity to identify any safety concerns and update the escalation status of the department, which was shared with the hospital's bed management team. The coordinator used an escalation trigger tool to determine the escalation status of the department (red, amber, green). For each issue identified there were actions required to mitigate the risk identified. For example, if patients were waiting longer than 15 minutes for triage, the coordinator was required to allocate a second nurse to triage and allocate a doctor to minors to see and treat patients.
- Full handovers took place three times a day, and more frequently in times of escalation. These were led by the senior doctor and senior nurse and each patient in the department was discussed. There was a safety checklist which ensured that safety issues, such as the frequency of observations were discussed.
- There was a sepsis screening bundle in use which prompted staff to consider, identify and manage sepsis. There had been regular lunchtime training sessions regarding sepsis and the junior and middle grade doctors had received specific training in sepsis. There was also a trust-wide campaign with online videos.
- Intentional rounding took place every hour for patients in the majors area. Intentional rounding is a structured approach whereby nurses carry out regular checks on patients' wellbeing, monitor their comfort and pain, assist them to change their position or with toileting and offer them food and drink where appropriate. Nurses were required to document this process hourly and compliance was monitored by reviewing a sample of five records per day. Data based on a sample of five patient records checked each day by the matron showed that on all but four days in February, two days in March and three days in April 2017, rounding took place appropriately. The matron told us that any learning needs identified would be discussed with the relevant staff member, although this did not form part of a regular recorded face to face clinical supervision.
- There was a 'safety net' system for reviewing and reconciling radiology reports. A consultant was allocated each day to review all incoming radiology reports. Results were notified to the relevant ward, team or consultant for inpatients, and to GPs for patients who had been discharged. In cases where reports identified missed injury or illness, consultants contacted patients by phone and/or letter. Learning from missed diagnoses was shared with staff at handover, printed out for staff to read in the staff room and raised with staff individually.

Nursing staffing

- Staffing had been reviewed using recognised acuity tools. Safe staffing levels and staff to patient ratios had been defined and increased since our last inspection. This included an increase in the nurse cover for the resuscitation area, which had increased from one to two nurses. The department had also employed a band seven nurse coordinator to manage patient flow from 8am to 11pm, seven days a week.
- The emergency department was consistently staffed with appropriate numbers of suitably skilled and experienced staff to ensure that people received safe care and treatment at all times. There were five band five nurse vacancies and recruitment to fill these permanently was continuing.
- The average registered nurse fill rate for November 2016 to April 2017 was 109.7%, with the lowest fill rate being one day in January 2017 (94.1%). The health care assistant fill rate for the same period was 109.21%, with the lowest fill rate being one day in November 2016 (84.6%)
- Bank staff completed orientation and training on the electronic patient record system before starting work. They then worked three trial shifts and feedback was sought form staff on their performance. All temporary staff were required to familiarise themselves with policies on falls prevention, pressure ulcer prevention infection control and sepsis.

- Staffing levels in majors were planned to provide a registered nurse to patient ratio of between one to four and one to six. When all cubicles were full and patients queued in the corridor, staff were required to care for up to eight patients. There were no patient safety incidents recorded related to nurse to patient numbers and acuity.
- There was a dedicated trained paediatric workforce in ED. There were eight registered children's nurses. All adult trained nurses received training as part of their induction and as part of the annual mandatory training day. Additionally, 19 nurses had completed a three day supernumerary rotation working with registered children's nurses to gain further competencies. Some adult-trained nurses had received additional training, including paediatric life support, to enable them to provide cover in the children's emergency department when required, for example when there were short notice absences or when the children's nurse escorted patients to the children's ward.

Medical staffing

- At our previous inspection there was a shortage of consultants; they were present in the department 14 hours a day during the week and for six hours a day at weekends. At this inspection we found the trust had recruited more consultants and reconfigured job plans to ensure greater senior presence. Consultant cover throughout the week was now provided in two overlapping shifts: 8am to 4pm and 2pm to 10pm. Cover at weekends was one consultant on duty 8am until 10pm and a second from 4pm to 10pm. Outside of these hours there was a minimum of an ST4 (specialist registrar year three) or above, supported by a consultant on call.
- At the time of our inspection there was one consultant vacancy and one long term absence. A locum had been employed to cover one of these gaps. There were three middle grade vacancies, all of which were covered by locums. Recruitment to these vacancies had not been possible and the department was looking at ways to reconfigure the roles and job plans in order to attract suitable applicants. Junior medical staff told us they were well supported by their seniors and had no hesitation in asking for support.
- Locum medical staff were employed to cover vacancies and other absences. We spoke with a locum doctor who told us they had received a comprehensive induction and felt well supported.
- There were structured medical staff handovers at the start of each shift, led by the consultant in charge. A checklist was used to ensure that all important safety matters were discussed. All patients in the department were discussed, including the plan for their careAll known risks and challenges were discussed, including waiting times and the hospital's bed state. The meeting was well attended and all staff were engaged.
- At the time of our inspection the emergency department did not employ a consultant who was dual trained in adult and paediatric emergency medicine. However, there was a named senior doctor allocated on each shift to cover the paediatric department There was also an on call paediatric consultant and registrar available 24 hours a day, seven days a week. The trust was seeking to appoint a dual trained consultant in forthcoming recruitment.

Major incident awareness and training

- The trust had a major incident plan, which was last reviewed in January 2017. This included an emergency department plan which set out detailed processes and roles in the event of a major incident. The trust told us a table top exercise took place in April 2017 and a communication exercise took place in March 2017. However, not all staff were up to date with training.
- There was a standing operating procedure to guide staff in the event of the electronic patient records system failing. Staff reverted to the use of a paper-based system in these circumstances.
- There were two security officers based in the hospital at any time and they could be summoned by staff in the emergency department via phone or pager.

Urgent and emergency services

Are urgent and emergency services effective?
(for example, treatment is effective)

Good

We found the requirement notices issued following our inspection in February 2016 had been met. We saw significant improvements in the emergency department and have changed the rating for effective from inadequate to good.

We have rated effective as good because:

- There was a range of recognised treatment protocols and care pathways in the emergency department.
- Compliance with pathways and standards was monitored through participation in national audits. Performance in national audits was mostly in line with other trusts nationally. There was evidence that audit was used to improve performance, for example in the treatment of sepsis.
- There was senior medical staff presence in the emergency department seven days a week, although consultant cover was reduced at weekends.
- Nursing and medical staff told us they felt well supported with regular teaching and appraisals.
- There was sepsis screening in place which prompted staff to consider, identify and manage sepsis. Since our last inspection there had been regular lunchtime training sessions regarding sepsis and junior and middle grade doctors had received specific training in sepsis.
- Performance against the sepsis standard (an hour from diagnosis to treatment) showed a significant improvement from April 2016 (18.5%) to January 2017 (47.5%) with a high of 61.2% in October 2016.
- Care was delivered in a coordinated way with support from specialist teams and services such as the stroke team. Doctors in the emergency department reported good working with specialists who reviewed patients in the department.
- Staff had easy access to relevant patient information which was updated as required on the arrival of the patient.
- Staff received training in the Mental Capacity Act 2005, including consent, as part of their mandatory safeguarding training. Most staff demonstrated a good understanding of the legislation.

However:

- There had been no recent audits in relation to pain relief. Reassessment of pain relief following analgesia was not consistently recorded.
- The unplanned emergency department re-attendance rate within seven days was generally worse than the England average and the national standard of 5%.
- There was no formal system of supervision for nursing staff, other than group supervision at annual mandatory study days.

Evidence-based care and treatment

- Care and treatment in the emergency department was delivered using clinical guidelines. These included National Institute for Health and Care Excellence (NICE) guidelines and the Royal College of Emergency Medicine's Clinical Standards for Emergency Departments.
- Compliance with pathways and standards was audited on a regular basis and education took place to continuously improve knowledge of, and compliance with, good practice.
- We observed prompt assessment and referral of a stroke patient, in accordance with protocol.
- We witnessed a junior doctor present the management of a patient with a pneumothorax to the assembled doctors at a handover meeting. The case provided a good example of the application of NICE guidance and local policy.
- At our previous inspection we raised concerns about the emergency department's poor performance in relation to sepsis management. Sepsis is a serious, potentially life threatening complication of an infection. There was a sepsis screening bundle in use which prompted staff to consider, identify and manage sepsis. Since our last inspection there had been regular lunchtime training sessions regarding sepsis and junior and middle grade doctors had received specific training in sepsis. There was also a trust-wide campaign with online videos.

- The trust quality improvement programme included sepsis pathway work with new pathways to be launched as part of Sepsis improvement work in April 2017, with a protocol for recognising and treating of paediatric sepsis.

Pain relief

- Patients we spoke with were comfortable and told us they had been asked about their pain and given pain relief when required.
- We saw in patients' records that pain had been assessed promptly and pain relief provided as required. However, reassessment of pain relief following analgesia was not consistently recorded.
- There had been no recent audits in relation to pain relief.

Nutrition and hydration

- We saw regular drinks rounds taking place in the emergency department. Domestic staff and volunteers served drinks and snacks under the supervision of nursing staff. Patients told us they had regularly been offered food and drinks.
- Nutrition boards detailing what patients could or could not eat or drink had been introduced following suggestions made by staff at a weekly 'huddle' meeting. This multidisciplinary meeting focussed on a specific topic to raise any issues of concern or share experiences.

Patient outcomes

- Information about patient outcomes was routinely collected and monitored. The emergency department participated in the Royal College of Emergency Medicine audits so they could benchmark their practice and performance against best practice and against other hospitals.
- In the 2015/16 RCEM audit: Vital Signs in Children, Torbay Hospital was in the lower quartile (performing worse) compared with other trusts for four of the six measures and between the upper and lower quartiles for two of the six measures. The measures that performed in the lower quartile were:
  - Measure (2) Children with any recorded abnormal vital signs should have a further complete set of vital signs recorded in the notes within 60 minutes of the first set.
  - Measure (3) There should be explicit evidence in the emergency department record that the clinician recognised the abnormal vital signs (if present).
  - Measure (4) there should be documented evidence that the abnormal vital signs (if present) were acted upon in all cases.
  - Measure (5) Children with any recorded persistently abnormal vital signs who are subsequently discharged home should have documented evidence of review by a senior doctor (ST4 or above in emergency medicine or paediatrics, or equivalent non-training grade doctor).
- Following the national audit the emergency department conducted snapshot monthly audits and the results were independently reviewed by the trust's audit team. Audits showed the department was consistently achieving targets in relation to observations and the frequency of audits was reduced to annual, with a further audit due in eight months' time.
- In the 2015/16 Royal College of Emergency Medicine Audit: VTE (venous thromboembolism) Risk in Lower Limb Immobilisation in Plaster Cast, the hospital performed in the upper quartile (performing better) for both measures compared to other trusts.
- In the 2015/16 Royal College of Emergency Medicine audit: Procedural Sedation in Adults, the hospital performed in the upper quartile (performing better) compared with other hospitals for three of the seven measures. Two measures were between the upper and lower quartiles and the remaining two measures were in the lower quartile (performing worse). The measures that performed in the upper quartile were:
  - Procedural sedation should be undertaken in a resuscitation room or one with dedicated resuscitation facilities.
  - Procedural sedation requires the presence of all of the below:
    - a doctor to give sedation
    - a second doctor, emergency nurse practitioner or advanced nurse practitioner to carry out procedure
    - a nurse
  - Following procedural sedation, patients should only be discharged after documented formal assessment of suitability, including all of the below:
    - Return to baseline level of consciousness
    - Vital signs within normal limits for the patient
    - Absence of respiratory compromise

    - Absence of significant pain and discomfort
    - Written advice on discharge for all patients
- Following this audit, the electronic patient record system was updated to include a procedural sedation section within the database and real time observation recording. There were plans to repeat this audit.
- The department generated monthly quality and safety information including the performance on sepsis standards (an hour from diagnosis to treatment). Performance against the standard showed a significance increase from April 2016 (18.5%) to January 2017 (47.5%) with a high of 61.2% in October 2016. The data was taken to and discussed at monthly clinical governance meetings. The quality and safety dashboard (which included Sepsis audit), was discussed at the monthly quality improvement group.
- The introduction of the rapid assessment process in majors had impacted on the department's performance, which had improved significantly. The department monitored and reported monthly on performance in relation to the time that patients were treated with antibiotics. The Royal College of Emergency Medicine standard is that 50% of patients should receive antibiotics within one hour (the golden hour). The standard was met from August to December 2016, dipping slightly below the standard in January 2017.
- We had also raised concerns at our last inspection about poor performance in the treatment of asthma in children. This was also the subject of teaching sessions and performance was being reviewed through participation in the most recent Royal College of Emergency Medicine audit.
- The unplanned emergency department re-attendance rate within seven days was generally worse than the England average and the national standard of 5%. Between February 2016 and January 2017 this ranged between nine and 11%.

Competent staff

- Nursing staff told us they felt well supported in terms of ongoing education, to ensure they maintained necessary competencies in their roles. There was a dedicated professional development nurse who had oversight of all nurse training. They also worked clinical shifts and supported staff in areas where they identified a learning need.
- There was no formal system of written supervision for nursing staff, other than group supervision at annual mandatory study days. Nursing staff were divided into three teams, each led by a team leader who could be approached for support, in addition to the professional development nurse. Informal teaching also took place during multidisciplinary handovers.
- A training needs analysis had been completed which set out essential and desirable competencies for nursing staff, and expectations in terms of career progression. Competency frameworks had been produced for each role/grade of nursing staff. Staff were required to maintain a portfolio to provide evidence that they achieved and maintained competencies and their performance was assessed and signed off by senior staff. A nursing staff training matrix was maintained for all mandatory and role-specific competencies.
- Junior doctors told us they felt well supported. There was weekly protected time for teaching. In addition, there were daily teaching sessions after the staff handover and informal teaching on the floor on a case-by-case basis. There was also a weekly journal club attended by medical and nursing staff.
- The majority of staff had received an annual appraisal. Appraisal rates had improved since our last inspection, with 76% of nursing staff and 100% of medical staff receiving an appraisal as at the end of March 2017. The trust's target was 90%.

Multidisciplinary working

- Care was delivered in a coordinated way with support from specialist teams and services. Doctors in the emergency department reported a good working relationship with specialists who reviewed patients in the department. We witnessed a multidisciplinary handover where emergency department doctors discussed the management plans for all patients in the department, with input from senior nurses, an occupational therapist and a medical consultant.
- Staff reported good working relationships with other departments within the hospital, including the emergency assessment units, paediatrics, the stroke team, radiology and the psychiatric liaison team.
- We spoke with staff about patients who required support in the community or patients who were homeless. We saw staff work with the discharge team who were able to contact agencies outside of the

emergency department, including the local authority. This helped ensure emergency department staff had the information needed to support safer discharge planning.

Seven-day services

- There was senior medical staff presence in the emergency department seven days a week, although consultant cover was reduced at weekends.
- The department had access to X-ray and radiology support 24 hours a day, seven days a week. This included rapid access to the CT scanner.
- Psychiatric support was available seven days a week.
- Pharmacy services were available between 9am and 7pm Monday to Friday and between 9am and 1pm at weekends. There was an on call pharmacist available outside of these hours.

Access to information

- Staff had easy access to secure relevant patient information. Individual patient records included historical personal information, which was updated as required when the patient arrived in the department, as well as details of previous emergency department attendances. Records were shared with other departments as needed.
- Staff had access to a bespoke electronic information system which allowed them to view real time information about individual patients and the activity in the department as a whole.
- Patient Group Directions (PGDs) in place which allowed some registered nurses to supply or administer certain medicines to a pre-defined group of patients without them having to see a doctor.
- Staff had access to clinical protocols and pathways via the intranet which supported evidence based care and treatment by staff. However, two medical staff told us they were not always easily accessible as they were not stored in a dedicated area.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff received training in the Mental Capacity Act 2005, including consent, as part of their mandatory safeguarding training. Most staff demonstrated a good understanding of the legislation.
- We observed staff seeking patients' verbal consent before undertaking care or treatment. Diagnostic tests and treatments were explained clearly to patients in a way they could understand and they were given time to ask questions. We saw that patients' consent was recorded in the sample of records we looked at.

Are urgent and emergency services caring?

Good

We have continued to rate caring as good because:

- Feedback from patients and relatives who used the emergency department was consistently positive.
- Patients told us staff were caring and compassionate, treated them with dignity and respect, and involved them in decisions.
- Staff showed an encouraging and supportive attitude to patients and their families.
- Patients and relatives were involved in decisions about their care.
- When patients experienced pain or discomfort staff responded in a timely and appropriate way.

Compassionate care

- We spoke with 17 patients and 15 relatives in the emergency department. Their feedback was consistently positive about the compassionate care and treatment they had received from staff. The comments we received during our discussions with patients included: "care has been fantastic and brilliant", "staff are so compassionate" and "I cannot speak highly enough of the accident and emergency staff because it doesn't matter how busy they are, they are always professional and friendly".
- The feedback we received was mirrored by the results of patient surveys in the emergency department. The trust used the NHS friends and family test to capture patient feedback. Results were consistently positive. Each month in the period from July 2016 to June 2017 over 93% of respondents (an average of 96%) indicated they were likely or extremely likely to recommend the service. Comments included: " Staff were all amazing, so friendly and instantly calmed me and made me feel less nervous…", " I was treated with kindness and respect" and "from the momment we walked in staff went out of their way to make us feel at home. Brilliant service."

- Staff were highly motivated and spoke passionately about the importance of providing kind and compassionate care.
- Staff were polite and introduced themselves by name and by role. They also wore name badges.
- Regular intentional rounding took place to ensure patients' comfort and wellbeing.
- Staff respected people's privacy and dignity We saw them drawing cubicle curtains during during examination and treatment. Maintaining privacy and dignity for patients who queued in the corridor was challenging but staff were aware of this and tried their best to manage this.
- Nurses, doctors and support staff provided care and treatment with kindness and patience. We observed that patients were not rushed, despite the department being very busy. One patient told us, "staff have been supportive of both my child and I, ensuring we are both okay and checking I don't need anything".
- When patients experienced pain or discomfort staff responded in a timely and appropriate way. All patients we spoke with reported their pain was assessed regularly and appropriate pain relief was given. One patient told us staff had recognised they were in discomfort and reacted and offered pain relief before they had reported being in pain.

Understanding and involvement of patients and those close to them

- Staff communicated with patients and their relatives so they understood their care and treatment. All patients we spoke with reported they were aware of the plan of care for treatment and said this information was given in a way they could understand. One patient told us: "everything has been explained in great detail". Another said: "I definitely feel part of my treatment and care".
- Patients and relatives were encouraged to be involved in their care as much as they felt able to. Patients we spoke with all confirmed this was the case and said they were given the opportunity to ask any questions or gain clarification if needed.
- Staff showed an encouraging and supportive attitude to patients and their families. We observed staff involving and encouraging both patients and their relatives as partners in their own care. We observed staff asking relatives, with the patient's consent, if they would like to be involved in discussions. One relative told us, "Staff value the opinions and views of relatives".
- Staff recognised when patients needed additional support to help them understand and be involved in their care and treatment. We spoke with a patient and relative whose first language was not English. They told us the nurse had checked they understood what was happening and whether there was a need for further clarification.
- Staff actively engaged with both patients and relatives. One relative told us: "As relatives we are part of the process and informed about problems and what to expect…".
- We heard a staff member discussing with a patient the impact their injury, healing process and rehabilitation may have on their ability to engage in their hobbies.
- Staff understood the importance of involving relatives, including parents of children and young people. Young adults and children we spoke with reported staff directed questions to them and then sought clarification from parents when required.
- Patients we spoke with told us staff were respectful of personal choices regarding treatment and care. Patients said they felt staff listened to their concerns and offered reassurance. A parent told us: "Staff are very respectful of both my son's needs and his wants". Another patient told us, "They are very responsive to needs and as an individual".

Emotional support

- We observed staff providing emotional support to patients and relatives during their visit to the department. Patient's individual concerns were promptly identified and responded to in a positive and reassuring way.
- Staff understood the impact the care, treatment or condition might have on the patient's wellbeing and on those close to them, both emotionally and socially. Staff told us they felt they not only had a duty of care to the patients, but also to their families. We overheard a staff member discussing the psychological impact an injury can have and offering support and reassurance to a patient.
- One relative told us staff had taken time to get to know their relative who had been admitted to hospital frequently. They said they were reassured to know their relative was in safe hands.

Urgent and emergency services

- Staff understood that emotional support extended beyond a patient's medical condition. We observed staff members comforting a child in distress, stroking their head and giving them time to respond in their own time.

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

Good

We found the requirement notices issued following our inspection in February 2016 had been met. We have changed the rating for responsive from inadequate to good.

We have rated responsive as good because:

- The emergency department had taken a number of steps to improve patient flow within the department. These included the introduction of doctor-led rapid assessment of ambulance patients. There was improved engagement with the rest of the hospital, including the bed management team, through the sharing of real time activity information.
- There was an escalation protocol which we saw working well, and the department had introduced a more streamlined triage process for self-presenting patients. These initiatives were reflected in sustained improved performance against national targets.
- The trust was meeting the national standard and performed better than the England average in relation to the standard which requires that patients wait 60 minutes or less from their time of arrival to the time their treatment begins.
- The trust exceeded the national standard and performed better than the England average in relation to the standard which requires the percentage of patients who leave the emergency department before being seen to be less than 5%.
- The trust was performing better than the England average in relation to the time that patients waited for their transfer from the time of the decision to admit.
- The trust was working collaboratively with commissioners and other stakeholders to identify system-wide strategies to improve patient flow.
- There was a responsive psychiatric liaison team and a dedicated mental health assessment area, which was a safe and calming environment for patients in mental health crisis.
- People's complaints and concerns were listened to and responded to promptly. We saw evidence of learning and improvement following complaints.
- There were arrangements in place to support bereaved relatives. There were bereavement booklets available providing information and sources of support. There was a chaplaincy service available in the hospital 24 hours a day, seven days a week.

However:

- The emergency department was not consistently meeting the standard which requires that 95% of patients are discharged, admitted or transferred within four hours of arrival. Performance showed an upward trend, significantly improved since our last inspection and better than the England average.
- Some patients spent too long in the emergency department because they were waiting for an inpatient bed to become available. Lack of patient flow within the hospital and in the wider community created a bottleneck in the emergency department, causing crowding.
- Lack of patient flow was compounded by a lack of space, which meant patients sometimes queued in the corridor, where they were afforded little comfort or privacy. When the department became congested, relatives had to stand because there was insufficient space or seating.
- The seating in the separate waiting area for children was limited to four chairs, some children had to wait in the main waiting area where they were overlooked by adults.
- The department had taken limited steps to support people in vulnerable circumstances, such as people living with dementia, or people with a learning disability.
- Patients' privacy was not always protected in the emergency department. The department had not taken any steps to prevent patients at the main reception desk or those seated from overhearing other patients' private conversations

- The bereavement (viewing) room in the emergency department was being used as a storage area and surgical waste bins were visible immediately adjacent to the relatives' room.

Service planning to meet the needs of local people

- Services were planned and delivered to take account of the needs of the local population.
- There was no barrier to accessing services on the grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief, or sexual orientation.
- The trust had worked, and continued to work, closely with other stakeholders and healthcare providers, including the ambulance service, GP and NHS 111, to identify system-wide strategies to improve patient flow. For example, improving discharge planning on wards to increase available capacity if patients needed to be admitted.
- The emergency department was well signposted and accessible by patients and visitors. There was parking available close to the department. There were two car parking areas, one within 50 metres (approximately 20 spaces with some for people who needed wide access into and out of their car) and the main car parking area within 100 metres of the department, with a small incline up to the department. Signposting within the department was clear and easy to follow. There was an information desk, staffed during the day by a receptionist who helped to direct relatives and visitors.
- There were vending machines in the waiting room where people could purchase hot and cold drinks and snacks. The department was equipped with toilets suitable for adults and children, including those with disabilities. There were also nappy changing facilities and an area for breast feeding mothers.
- There was a separate waiting area for children, which was suitably decorated, furnished and equipped. It had restricted access and was not overlooked by the adults' waiting area. However, seating in the waiting area was limited to four chairs so some children had to wait in the main waiting area where they were overlooked by adults.
- Facilities and premises were not wholly adequate. In the majors' area, patients frequently queued in corridors, either while they were waiting to be seen or while waiting to be transferred to a ward. Patients' relatives sometimes had to stand because there was insufficient seating. Limited storage facilities also impacted on congestion in the department. There was adequate seating in the waiting rooms during our visit, although staff told us there was standing room only on occasions.
- The corridor, where ambulance-borne patients waited for assessment, and the rapid assessment area, located just inside the ambulance entrance, were draughty. Sliding doors were continuously opening, creating a rush of air and wind, which at times was strong enough to blow cubicle curtains around.
- Patients' privacy was not always protected in the emergency department. The department had not taken any steps to prevent queuing patients at the main reception desk, or those seated in the waiting room, from overhearing other patients' private conversations with the receptionist. The newly created 'triage pod' in the main waiting area, whilst improving safety by enabling the triage nurse to view the waiting room, was partially open, meaning private conversations could be overheard if the department was quiet. However, patients required to remove clothing or discuss intimate matters could be seen in private side rooms. The handover and assessment process in the majors' area was undertaken in the corridor and/or in the rapid assessment cubicle.
- Patients were given information about the emergency department and what to expect. Self-presenting patients were given an advice leaflet on arrival which explained the various pathways through the department and provided a range of useful information. There was also a poster displayed which explained the triage process, and a range of leaflets about common illnesses and injuries. There were plans to display waiting times in the department and in local minor injuries units (currently available on the trust's website) on a television screen in the waiting room.
- There was a bereavement (viewing) room in the emergency department. At our last inspection we highlighted it was being used as a storage area and this was still the case at this inspection. Although some remedial work had been undertaken, including introducing two chairs and a picture, the environment remained clinical in appearance. There was a pleasant, comfortable relatives' room which was equipped with facilities to heat food and make drinks. We noted, however, the window looked out onto large waste bins.

Urgent and emergency services

Meeting people's individual needs

- The service took account of the needs of individual patients but was not always able to provide a responsive service due to capacity in the department and the wider hospital. There was limited support available for people in vulnerable circumstances, such as patients living with dementia and those with a learning disability.
- The emergency department was accessible for people with limited mobility and people who used a wheelchair. Fixed seating in the waiting room could not accommodate bariatric patients but the department had a suitable trolley and could request equipment from within the hospital if required.
- Information in alternative formats was available to support patients and relatives with communication difficulties. Interpreters were available by telephone to support people whose first language was not English. Documents could be provided in different languages and formats, including braille, audio and large print information.
- The trust had an accessible information policy, which included information about supplying information in 'easy read' format, interpretation and translation services. The policy was due for review in July 2017.
- The department had access to a service which provided specialist support for deaf patients or parents. An interpreter could be contacted and staff told us this was a very quick and responsive service. There was a hearing loop in reception to assist people who used a hearing aid.
- The emergency department was supported by a psychiatric liaison team provided by the local mental health trust. They conducted mental health assessments of patients in the emergency department during daytime hours, seven days a week. They aimed to respond to referrals within one hour. In the year April 2016 to March 2017 the team met this target 74% of the time. While 26% of patients where not responded to within the hour, there were no breaches of the four hour wait target in the overall trust analysis of breaches related to mental health team patients.
- The out of hours service for adults with mental health issues was run by a nurse practitioner, supported by a junior doctor and a consultant on call. Staff told us the service was usually responsive, but frequent delays were experienced when a patient required admission to a mental health hospital. However, data provided by the trust did not show any breaches of the four hour target resulting from delays for these patients. Staff expressed concerns about the suitability of the emergency department as an environment for patients waiting who were in mental health crisis. There was an out of hours service for children and adolescents with mental health issues.
- A newly created mental health assessment room was a welcoming and calming environment, located away from the hustle and bustle of the busy department. However, this space was only used for assessment. Patients awaiting assessment or awaiting a hospital bed were accommodated in the emergency department or, if suitable, the clinical decision unit. Neither of these spaces offered a calm or private environment for patients who may be anxious and agitated.
- There was a drug and alcohol team available from another provider, which patients were advised to self-refer to. The alcohol team were available Monday to Friday 9am to 5pm, and the team who supported issues related to drug misuse were available Tuesday 10am to 12pm and 1.30pm to 3.30pm, Wednesday 3pm to 7.30pm and Friday 10am to 12pm. Patients were given a lifestyle screening questionnaire which they could complete if they considered they needed advice or support with issues such as smoking, drinking alcohol or drug misuse. Advice could be given, including referral or signposting to other agencies.
- The department provided 'twiddlemitts' for patients who were restless or anxious. Twiddlemitts are knitted mittens with items of varying texture attached inside and out. They are knitted by volunteers using brightly coloured wool and lots of attachments. They provide simple stimulation for people with dementia and other memory conditions. They minimise agitation, increase flexibility of the fingers and soothe fidgety hands.
- There were arrangements in place to support bereaved relatives. There were bereavement booklets available providing information and sources of support. Information was available for adults and children. There was a chaplaincy service available in the hospital 24 hours a day, seven days a week.
- We spoke with staff about support for patients who required support in the community or who were homeless. Staff told us they were able to contact agencies outside of the department and ensured the emergency department staff had the information

needed to support discharge planning. Where patients were homeless they could contact local hostels to find suitable accommodation at short notice. For longer term discharges, the discharge team would liaise with social services.

- A patient we spoke with told us staff were "… very responsive to needs and as an individual".
- There was a learning disabilities nurse who provided support on request to all hospital departments, including the emergency department. There was a flagging system to identify known patients with a learning disability. However, this would not automatically alert the learning disabilities nurses, who told us they were not always informed when a patient with a learning disability was in the hospital. Staff awareness of their responsibility to identify patients was mixed.
- The emergency department had taken limited steps to support patients living with dementia. We were told staff received dementia awareness training as part of their induction, and occasional updates from designated dementia champions. There were no alerts used to identify patients living with dementia. There were three identified dementia champions in the department; however, we were told they did not meet regularly. We were also told there was a dementia resource folder in the department but this could not be located during our inspection. Staff told us they would try to accommodate patients living with dementia in a cubicle directly opposite the nurses' station so they could closely supervise them and support anxious, confused or agitated patients. We saw such a patient moved to this cubicle when it became available. However, we observed three nurses stood at the nurses' station with their backs to the patient for ten minutes.

Access and flow

- Patients did not always access care and treatment in a timely way. Patient demand frequently exceeded capacity within the emergency department and this resulted in a poor experience for some patients.
- The emergency department was consistently failing to meet the national standard which requires that 95% of patients are discharged, admitted or transferred within four hours of arrival. However, performance was showing an upward trend and was better than the England average. Monthly performance in the last quarter of 2016/17 was 81.4% in January, improving to 84.3% in February and 91.5% in March.
- It was reported at the April 2017 trust board that the emergency department breach analysis showed the main reasons for delays were delayed access to beds and delayed clinical decisions for patients requiring emergency admission.
- Escalation processes had been improved since our last inspection. The trust operated a very effective 'operational pressures escalation level' (OPEL) response, which supported the emergency department. OPEL is graded one to four, with four being the highest level and identifying that significant levels of demand could leave the trust unable to deliver comprehensive care unless the situation is managed. On the first day of our inspection the trust escalated to OPEL four due to high demand and system-wide pressures following the bank holiday weekend. We witnessed a system-wide multidisciplinary response to the escalation. Real time information was regularly shared with the bed management team and the rest of the hospital to improve shared ownership of patient flow. Full handovers for each patient in the dpeartment took place several times a day during escalation and these were led by the senior doctor and senior nurse. The escalation response was rapid and effective, with the escalation level being downgraded later the same day.
- Day-to-day, the coordinator used an escalation trigger tool to determine the escalation status of the department (red, amber, green). For each issue identified there were actions required to mitigate the risk identified. For example, if patients were waiting longer than 15 minutes for triage, the coordinator was required to allocate a second nurse to triage and allocate a doctor to minors to see and treat patients. Also, two-hourly safety barometer checks conducted by the emergency department coordinator were an opportunity to identify any safety concerns and update the escalation status of the department, which was shared with the hospital's bed management team.
- While waiting no more than four hours from arrival to departure is a key measure of the emergency department 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 median wait of

below 60 minutes. At our last inspection we reported patients sometimes waited up to three hours to see a doctor. Performance had significantly improved as a result of the recruitment of more consultants and the introduction of rapid assessment led by a consultant or other senior doctorThe trust met the standard for seven months over the 12 month period between February 2016 and January 2017 and had consistently met the target since June 2016.

- Performance against this standard showed a trend of improvement from June 2016 onwards. In February 2017, the median time to treatment was 40 minutes compared to the England average of 57 minutes.
- Another important indicator for patients who require admission to a hospital ward is the time it takes for their transfer to take place from the time of decision to admit. InMarch 2017, 45 patients (approximately 2%) waited between four and 12 hours from the time of decision to admit. No patients waited more than 12 hours. This was an improving picture and performance was better than the England average.
- Staff told us patients who were delayed in the department for long periods of time, including overnight, were provided with hospital beds.
- The emergency department worked closely with the hospital operations team, which was responsible for patient flow and bed management. The operations team met three times a day or more frequently if required.
- Between February 2016 and January 2017 the emergency department consistently performed better than the England average for the number of patients who left the department before being seen by a clinical decision maker. The national target for this is less than 5%. In February 2017, the trust reported 2% of patients leaving before being seen, compared with an England average of 3%. The trust's performance had shown improvement over time.
- There were a number of initiatives in place to prevent unnecessary emergency department attendance and improve patient flow within the department:
- The trust had an 'Alternatives to Admission Policy', which set out a range of direct referral pathways and sources of advice to GPs to manage patients where admission via the emergency department may not be necessary.
- The clinical decision unit was located close to the emergency department and had eight chairs. The unit was used for mobile patients referred by the emergency department who were waiting for test results or further medical review.
- There was a standing operating procedure which set out the protocol for the direct admission of expected patents who had been referred by their GP. However, staff told us that most of the time these patients were admitted via the emergency department because there were no available beds on the emergency admissions unit.
- There was a rapid assessment area in the majors' area of the emergency department. This was designed to improve patient flow by ensuring patients were examined promptly by a senior clinician so that decisions about diagnostic tests, and treatment plans were made more quickly.
- The trust's website published live information about waiting times in the emergency department and the trust's five minor injuries units (MIU). There was also information about opening times of MIUs, the facilities available (such as X-ray) and those injuries and illnesses which could be treated in an MIU setting. There were plans to display this information on a screen in the emergency department waiting room.
- There was an emergency department redirection policy, which allowed triage nurses to redirect appropriate patients to other sources of health care, such as their GP, dentist, pharmacy or MIU. There was a set of criteria which helped staff to determine which patients may be suitable for redirection and a set of exclusion criteria.
- There were internal professional standards for in-reach specialty review of patients in emergency department (ED). Specialties were required to respond within two hours of referral from the emergency department. Performance against the 'two hour' standard (April 2017) was 90% in hours and 75% out of hours. The clinical lead acknowledged there was further improvement required in this area.
- The department had introduced a 'bed ready - go' policy, which enabled staff to transfer patients to an available inpatient bed as soon as it was allocated on the hospital's electronic system. Previously staff had encountered delays because they had to telephone the ward prior to the transfer taking place.

Urgent and emergency services

Learning from complaints and concerns

- People's concerns and complaints were listened to, responded to and used to improve the quality of care.
- Patients were encouraged to raise concerns if they were dissatisfied with any aspect of their treatment. Complaints leaflets were available in the emergency department. Staff were familiar with the complaints process. They told us they would try to resolve people's concerns immediately themselves or they would refer to a senior member of staff. If concerns could not be resolved locally, staff referred people to the Patient Advice and Liaison Service (PALS). PALS information was displayed on noticeboards throughout the department.
- We saw from the department's complaints register that complaints were investigated and responded to promptly. In the event of any delays, complainants were kept informed.
- Lessons were learned from complaints and actions taken to address any shortcomings identified. Staff involved in complaints received individual feedback and lessons learned were discussed at regular handover meetings and communicated via email. There was also a communication book kept in the staff rest room, where printed emails were stored.

Are urgent and emergency services well-led?

Good

We found the requirement notices issued following our inspection in February 2016 had been met. We have changed the rating for well-led from inadequate to good.

We have rated this domain as good because:

- There was a strong, cohesive and well-informed leadership team who were highly visible and respected.
- There was a detailed improvement plan in place with clear milestones and accountability for actions.
- The emergency department produced high quality information which analysed demand capacity and patient flow, and was used to inform the improvement plan.
- There were robust governance arrangements in place. Risks were understood, regularly discussed and actions taken to mitigate them.
- There were cooperative and supportive relationships among staff. We observed excellent teamwork, particularly when the department was under pressure.
- Staff felt respected, valued and supported. Morale was mostly positive, although to an extent was undermined by workload pressures. Staff also spoke passionately about the values which underpinned their work; safety, quality and compassionate care.
- Service improvement was everybody's responsibility. Staff had been engaged in the improvement journey and had been encouraged to participate in service re-design and make suggestions for improvement.

However:

- Staff we spoke with could not articulate a vision and were not aware of the overall improvement strategy and how it linked with the wider hospital system.
- Regular mortality and morbidity meetings were not taking place, with the last having been in August 2016. Mortality and morbidity related issues were not discussed in emergency department clinical governance meetings.

Vision and strategy for this service

- There were a number of strategies for the emergency department. These were outlined in the urgent and emergency care action plan 2017/18. The plan was to deliver a fully integrated 'front door' by addressing problems such as delays, environment and skills, as well as links with other stakeholders including the ambulance service. The overarching improvement plan set out short and medium term strategies and objectives, with accountability for actions and deadlines monitored.
- Staff we spoke with could not articulate a vision and were not aware of a strategy but they all passionately described the values which underpinned their work; safety, quality and compassionate care.

Governance, risk management and quality measurement

- We noted significant improvement in this area. There was an effective governance framework. Information was regularly monitored to provide a holistic understanding of performance, including safety, quality and patient experience. This included audits of early warning scores in children and adults, safeguarding and intentional rounding.

- Weekly performance reports were reviewed by senior staff and discussed at handover meetings. The emergency department held monthly governance meetings, attended by consultant and middle grade doctors, the senior nurse and the trust's Associate Director of Nursing. Items discussed included incidents, complaints, performance metrics, the department's risk register and any new clinical guidance. Action logs were produced and reviewed at the next meeting. Minutes of meetings were distributed via email and key messages were delivered via daily staff handovers, targeted teaching and education noticeboards.
- The emergency department maintained a risk register which was regularly monitored and reviewed at departmental and divisional levels. Risks aligned with the areas of concern identified to us by managers and staff, with the highest risk being associated with demand, capacity and patient flow. Risk mitigation included the development and implementation of an overarching strategy for patient flow, effective escalation protocols and increased numbers of staff of the appropriate grade.
- Arrangements with third party providers were well managed. There was regular engagement with the mental health trust which provided the psychiatric liaison service and the ambulance service.
- Following our last inspection the trust put in place a CQC Assurance Group, attended by executive managers and the CCG. The group met monthly and was responsible for the oversight of the emergency department improvement plan. The assurance group reported to the Patient Flow Board and ultimately, to the trust board. The assurance group had recently been stood down because there was confidence in the local management team and governance processes.
- The trust told us there were quarterly mortality and morbidity meetings where the care of patients who had complications or unexpected outcomes was reviewed. However we found that the last meeting had taken place in August 2016; the meeting scheduled for January was cancelled due to winter pressures and had been re-scheduled to take place in May 2017.
- Mortality and morbidity related issues were not discussed in emergency department clinical governance meetings. The most recent clinical governance meetings for the department held 14 March and 18 April 2017 did not include discussion regarding mortality and morbidity.

Leadership of service

- There was a leadership triumvirate consisting of the clinical lead (consultant), matron and business support manager. The department had also been supported by an improvement manager. They were a strong, cohesive and well informed team, who were highly respected by staff.
- Staff told us managers were visible, approachable and supportive. The matron was reported to be "very hands on" and regularly supported staff on the floor. The divisional director of nursing was also reported to be a regular visitor in the department, helping with patient transfers. Staff told us the Chief Executive had visited the department a few times over the Christmas period and the trust's medical director was also more visible than had previously been the case.
- Staff told us they felt valued and appreciated by managers. Letters of thanks from grateful patients and colleagues were shared with staff and their contribution recognised.

Culture within the service

- The culture in the emergency department was described to us by staff as one of pride and optimism for the future. Staff were proud of the improvements which had been made in the last 15 months and contrasted their feelings of despondency then to their feelings of pride and optimism in the present. Teamwork was cited by many staff as being the best thing about working in the department and they believed the improvements which had been achieved were testament to a team approach to tackling the challenges they faced.
- Team building away days had recently been held for nursing teams. There were three teams, each identified by a safety theme: sepsis, pressure ulcer prevention and falls. Each team spent half a day discussing their respective safety themes and the remainder of the day was spent doing team building activities. The sepsis team were involved in producing sepsis prompt cards to be given to all staff, including temporary staff.
- Staff told us they felt respected, supported and valued by their immediate managers and their peers. Staff morale was mostly very positive. A healthcare assistant told us how much they enjoyed working in the department and how they had been inspired to start their nurse training. Another healthcare assistant told us they had worked in the emergency department as a

bank staff member and had enjoyed it so much that they had joined the substantive workforce. To some extent this positive morale was overshadowed by concerns about workload and capacity, with staff describing feeling overwhelmed and drained at times when the department was very busy.

- Staff in the emergency department were invited to complete a friends and family survey to indicate whether they would recommend their department as a place to work. In February 2017, 12 out of 17 respondents indicated they were either extremely likely or likely to recommend the department as a place to work.
- Staff told us they felt their safety and wellbeing were important to managers. Several staff told us how they had been supported during difficult periods in their home lives. Staff with family commitments were accommodated to work flexibly. De-briefing following difficult and traumatic situations at work was provided by senior staff.
- There was a culture of openness and honesty. Staff told us they felt able to report concerns and were confident they would be listened to.

Public engagement

- The emergency department captured views and experiences using feedback questionnaires. A number of improvements made in the department in response to negative feedback featured in a poster displayed within the department. These included replacing metal bins with plastic ones to reduce noise and disturbance, carrying out the board round in the staff station so that patients and visitors did not overhear confidential information, and improving signage to the emergency admissions unit.
- The department had worked with the local Healthwatch to canvass their views about the reconfiguration of the waiting room and the triage area, prior to introducing this.

Staff engagement

- Staff told us they had been actively involved and their views had been listened to during the improvement journey which had taken place since our last inspection. Process mapping exercises had taken place, and working groups had been established to ensure staff were engaged in the change process. Managers told us this had increased staff acceptance of new processes and was fundamental to their success. One consultant told us the culture shift that had taken place since our last inspection was probably the most important improvement and believed this had come about due to staff engagement in the improvement journey. They said "staff have a can do attitude, rather than saying what's the point?"
- Staff felt able to raise concerns. There were weekly multidisciplinary huddles, each focussing on a specific topic but also providing a forum for staff to raise any issues of concern or share experiences. 'You said, we did' messages were produced after each meeting and posters were displayed in the staff room. Topics discussed included communication, nutrition and safeguarding. The department had also appointed 'go to champions', who were identified staff members who staff could approach confidentially to raise any concerns if they were not comfortable raising them in a more open forum.

Innovation, improvement and sustainability

- There was a strong sense of focus and drive to improve safety and quality. Staff spoke passionately about their desire to improve the service for patients and they were proud of the improvements they had made since our last inspection. There was an emergency department improvement plan which had been developed in response to a number of drivers, including our last inspection. Progress against milestones was reported monthly to the trust-wide patient flow board, chaired by the trust's medical director.
- The trust participated in a 'perfect week' at the end of February 2017. This is a process used by many NHS organisations where all resources are focussed on achieving perfection in terms of patient flow, and adopting learning from that experience. During the perfect week the emergency department tested the rapid assessment process, which was found to have a significant effect on patient flow within the department and improve performance against the four hour target. There was learning about how the system could be made more efficient and this learning was being put into practice. For example, there was enhanced earlier senior clinician review of patients on wards as well as improved efficiency in the emergency department such as more rapid assessment and decision making.
- In March 2017 the trust had a visit from the Emergency Improvement Care Programme. This was an invited visit

to review progress since an earlier review two years previously. The report noted many positive initiatives to support improved flow and decision-making and made a number of recommendations for further improvement, which were included in the department's and wider urgent care system action plans.

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

The medicine division provides medical care services at Torbay Hospital.

Acute medical services include six inpatient wards, two cardiac catheterisation laboratories, one stroke unit, an acute respiratory unit, a bronchoscopy service, and a fully integrated heart failure and arrhythmic team. The directorate also manages an endoscopy unit, an oncology day unit and the Torbay Assessment Investigation and Rehabilitation Unit. Two wards are dedicated to healthcare for older people. A surgical ward also has beds available for medical patients. There are two emergency assessment units (EAUs) and an acute medical unit (AMU), which is used for ambulatory care.

The medicines division had 40,185 medical admissions between December 2015 and November 2016. Emergency admissions accounted for 18,045 (45%), elective admissions accounted for 1,259 (3.1%) and the remaining 20,881 (51.9%) were day cases. The majority of patients (43%) were seen in general medicine, with 23% seen in gastroenterology and 9% in clinical oncology.

This inspection was unannounced and was carried out to see if improvements had been made following our comprehensive inspection of the trust in February 2016. At our last inspection medical care was rated as requires improvement in all domains except caring, which was rated as good.

We visited all of the medical care areas, including wards used for medical outliers. To help us understand the quality and safety of medical care services, we spoke with the leadership team responsible for this directorate as well as 65 staff of all levels and specialties. We also spoke with 26 patients, relatives and carers, observed care in all clinical areas and looked at 27 sets of patient records.

Medical care (including older people's care)

Summary of findings

We found the trust had addressed the requirement notices from our inspection in February 2016 and had made improvements in the effective, responsive and well-led domains. These three domains have changed from requires improvement to good. We still had some concerns around the safety of the service and this domain continues to be rated as requires improvement.

Overall we rated medical care as good because:

- Recent reconfiguration of consultant working rotas had resulted in improved availability of senior physicians at the weekend.
- There was effective and consistent use of evidence based practices for patients in the medicine division.
- Multidisciplinary working was truly embedded throughout the division, both internally and externally to the hospital. This was particularly evident in the management of an OPEL four alert.
- Patients said staff were caring and compassionate, treated them with dignity and respect, and as an individual.
- Staff were skilled to be able to communicate well with patients and keep them informed of what was happening and involved in their care.
- Staff had knowledge of patients' circumstances and the impact their health had on them and their families.
- The division consistently met targets for senior review of acutely admitted patients both in and out of hours.
- A twice daily multidisciplinary meeting steered patient care and ensured actions were completed to advance diagnosis and treatment.
- The division worked closely with community based colleagues to ensure an efficient and safe step down process was in place for discharged patients.
- Emergency admissions units were used effectively to admit, and assess patients in a timely way and worked effectively with the emergency department.
- There was a focus on ensuring key messages from the governance team reached front line staff, and staff had a broad understanding of the direction of the medicine division.
- Staff felt connected to their line managers, able to raise concerns and make suggestions.
- A supportive and open culture was evident throughout the areas we visited.

However:

- The environment on many of the medical inpatient wards was sub-optimal with cluttered conditions that could impact on the safety of vulnerable patients.
- Confidential patient records were not kept securely; records were stored on open shelves in the ward areas.
- Risk assessments were not always completed comprehensively, or signed legibly by nursing staff. Medical records and prescription charts were only signed legibly in two of the sets of records we looked at.
- Completion of safeguarding adults training at level three regularly fell below trust targets.
- Data collated showing the completion of discharge summaries demonstrated a poor performance against trust targets.
- Day rooms on the care of the elderly wards were not being used by patients. On Simpson ward the day room was very unappealing and sparse.
- Patients with dementia were not always cared for in line with national guidance. Performance against the dementia FIND targets fell substantially below expected levels.
- Staff felt poorly informed about the plans for acute bed closures and this caused anxiety and uncertainty in many staff we spoke with.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

We found the requirement notices issued following our inspection in February 2016 had been met. However, we found additional concerns that meant the safe rating remained as requires improvement.

We rated safe as requires improvement because:

- Confidential patient records were not kept securely; records were stored on open shelves in the ward areas.
- The environment on many of the medical inpatient wards was sub-optimal with cluttered conditions that could impact on the safety of less mobile patients.
- Fire escape routes on Cheetham Hill and Turner wards were cluttered with equipment.
- Daily checks of resuscitation trolleys were not consistently completed across the medical wards.
- Systems aimed at ensuring the safety of medicines were not always effective. On two wards we visited, we found intravenous fluids were out of date and recording of refrigerator temperatures was inconsistent.
- Risk assessments were not always completed comprehensively, or signed legibly by nursing staff. Medical records and prescription charts were only signed legibly in two out of the 27 sets of records we looked at.
- Completion of adult safeguarding training regularly fell below trust targets.

However:

- There was a positive incident reporting culture with clear examples of changes in practice as a result of learning from incidents.
- Nursing staffing levels were maintained at safe levels with additional staff available for more dependent patients.
- Recent reconfiguration of consultant working rotas had resulted in improved availability of senior physicians at the weekend.
- Systems were in place which ensured the assessment and management of patient risk was identified at the earliest possible opportunity.

Incidents

- Staff understood their responsibilities to raise concerns, record safety incidents and near misses and to report them internally and externally. Staff told us the electronic reporting system, which had been recently introduced, was easy to use. Staff received an automated response when they reported an incident and individual feedback if they requested it. All nurses we spoke with described an open culture of incident reporting, which meant staff felt confident and supported to report practice they felt could be improved. Staff told us that learning was encouraged and communicated clearly following incidents.
- The trust reported 11 serious incidents which met the reporting criteria set by NHS England in the medicine division between March 2016 and February 2017. Of these, the most common type of incident reported was Slips/Trips/Falls, which accounted for 27% of all incidents. We looked at the investigations of a sample of serious incidents and found staff used the National Patient Safety Agency (NPSA) national framework for reporting and learning from serious incidents to improve practice. Senior clinical and operational staff formed a root cause analysis team for each incident and conducted a systematic and robust investigation of the incident and ensured improvements were identified and implemented.
- All pressure ulcers graded two to four were reported via the trust's incident reporting system. The tissue viability service reviewed any grade three or four pressures ulcers. However, they did not investigate the cause because it was felt this needed to be done by the ward staff to help with learning. Support was available from the team to assist with this.
- A monthly newsletter produced by each ward detailed the incidents reported and any themes. This was aimed at staff working on the wards. We were told incidents were also discussed in team meetings where they were significant or if changes in practice occurred as a result. We were given an example where a patient had sustained an injury to their hand in bed. Staff identified how the bed could be adapted for the patient so it did not recur and the bed was adjusted accordingly. Daily safety briefings also informed staff of any relevant changes to practice as a result of incidents.
- Between March 2016 and February 2017, the medicine division reported one incident which was classified as a

never event. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. The incident involved oral medication being given intravenously. The trust made immediate changes to the medication packaging to reduce the risk of this happening again. We saw evidence of the investigation following this incident, together with learning which was disseminated across teams, and changes to practice as a result.

- Mortality and morbidity meetings were held and attended by a variety of members of the multidisciplinary team. Cases were discussed, alongside opportunities for learning and changes to practice. We looked at a sample of meeting minutes within the endoscopy service, for the time period June 2016 to February 2017. We found discussions were comprehensive; however, the minutes rarely detailed any learning from cases that would be taken forward. Of the 12 patients discussed, only four had any identified learning documented in the minutes.

Duty of candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- The trust's incident reporting policy included guidance for the duty of candour. Staff at all levels were confident in their responsibilities around duty of candour. We were given examples by front line staff of when they had talked to patients following medicine errors, and were supported to do so by their managers. We also looked at some letters sent to patients where duty of candour had been applied and found them to be clear supportive, and offering an apology. Patients and their families were offered meetings and updates on an ongoing basis.

Safety thermometer

- The safety thermometer is used to record the frequency of patient harm. It provides immediate information and analysis for frontline teams to monitor their performance in delivering harm-free care. Measurement at the frontline is intended to focus attention on, and reduce patient harm. Data collection takes place one day each month.
- Data from the patient safety thermometer showed the medical services reported 11 new pressure ulcers, 21 falls with harm and eight new catheter-acquired urinary tract infections between February 2016 and February 2017.
- Not all areas displayed their safety thermometer data in clearly visible areas. On Cheetham Hill ward for example, it was on a wall in a cluttered office restricted to staff. It was not clear how staff were using the information on the safety thermometer to inform practice on a ward by ward basis.

Cleanliness, infection control and hygiene

- Standards of cleanliness and hygiene were maintained by a cleaning and housekeeping team. Ward areas were visibly clean, and free from offensive odours. We saw cleaning staff worked continuously during our visit.
- Handwashing sinks were readily available in all areas we visited and had supplies of handwashing soap. In addition, there were plentiful supplies of hand cleansing gel away from sinks for staff and visitors to use. We observed all staff either washing their hands or using gel between patients and at regular intervals. We saw there were plentiful supplies of aprons, gloves and other protective items available for staff.
- All staff adhered to the trust's policy of "bare below the elbows", which promoted good infection prevention and control.
- Implementation of safety systems and processes was monitored by the trust. The infection prevention and control team operated a system of audit which monitored compliance with infection control policies, and produced action plans to ensure continued improvement. Hand hygiene audits showed overall compliance across the medicine division with hand hygiene guidelines averaged between 88% and 100% in the six months prior to our inspection. However, there were some significantly lower scores on individual wards, with Warrington ward obtaining only a 50% score in January 2017. This had improved to 100% in March and April 2017. Dunlop ward achieved only 60% in the

December 2016 audit, but improved to 100% in the four months that followed. These figures suggested learning was taken from the poor performance and practice improved.

- In the year April 2016 to March 2017, the trust reported nine cases of Clostridium difficile on medical wards. In the same reporting period, one case of Methicillin-resistant Staphylococcus Aureus (MRSA) and 16 cases of Methicillin-sensitive Staphylococcus Aureus (MSSA) were reported in the division. For cases of MRSA and MSSA, root cause analysis investigations were carried out to identify the cause of infection and provide learning which aimed to prevent recurrence.
- Side rooms were used to care for patients with infectious illnesses, or where there was a suspicion of an infectious illness. We saw staff observed enhanced infection prevention and control practices with these patients, such as an increased use of personal protective equipment, like aprons. Where there was known infection in particular areas, this was clearly notified on ward entrance doors.
- The endoscopy unit had facilities to maintain infection control procedures safely. The unit had a decontamination area, which was separate from clean areas. The scopes were cleaned as per recommended guidelines and stored in cabinets with details of their cleaning date and when they needed to be re-cleaned if not used.
- We looked at the storage of cleaning chemicals and found them to be compliant with Control of Substances Hazardous to Health (COSHH) guidelines.
- We looked at the daily cleaning schedules for toilets and showers on four of the wards we visited. We found them to be completed at least twice daily for the month prior to our inspection.
- We saw where equipment had been cleaned it had a sticker attached which told others it was ready for use.
- The medication administration records included a care plan for the management of cannulas. This required staff to review the cannula for signs of infection. The use of a cannula was reviewed daily and staff were asked to consider whether it could be removed if it was not needed. There were instructions about the management of cannulas with signs of infection and we saw staff following these.

Environment and equipment

- The design and use of premises did not always keep people safe. The environments on Cheetham Hill, the George Earle stroke unit, and Simpson wards were cluttered with many obstacles that prevented ease of movement through the ward areas. Long narrow corridors between bays were filled with laundry trolleys and bags of laundry, together with desks, chairs and other equipment. Hand rails were not always accessible to patients who may need them because they were blocked by various pieces of equipment. The floor on Simpson ward was breaking up in several places, which was not only unsightly but meant cleaning could not be as thorough as it needed to be for infection control purposes.
- Arrangements for managing waste and clinical specimens did not always keep people safe. Waste bins for clinical and non-clinical waste were clearly distinguished and emptied regularly. Clinical specimens were clearly labelled and sent away or tested promptly. Sluices were clean, orderly and used appropriately. However, not all wards were compliant with the European Waste Framework Directive (2008/98/EC) or the Health and Safety Executive Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 because sharps bins were not always stored or labelled correctly. For example, on Cheetham Hill ward, we found a sharps bin had been assembled which was neither labelled nor closed. Inside the sharps bin was a clearly visible "butterfly" needle connected to a tube containing blood.
- Side rooms on Simpson ward did not benefit from en suite toilet facilities. Patients with infections therefore used commodes which needed to be wheeled to the sluice through the corridor.
- The lack of space on the care of the elderly wards meant doctors had conversations at desks situated in corridors, which were in clear earshot of patients. These conversations included discussions around diagnosis, diagnostic test results and discharge planning.
- The acute medical unit contained mainly seating for ambulatory patients. It had six rooms with trolleys used for consultations and examinations. There was an additional room specifically for the care of patients with suspected deep vein thrombosis. We were told that during the afternoons on the unit there were often not

enough rooms with trolleys available and as a result patients spent longer waiting to see a doctor. Whilst this unit was relatively new, it felt cramped with patients waiting in small waiting areas.

- We visited the Torbay Assessment, Investigation and Rehabilitation Unit (TAIRU). This was a day unit where patients were admitted for infusions, blood transfusions, investigations and reablement. We observed one of the fire exits was blocked by a trolley and seated weighing scales. This was reported back to the trust who immediately took action to rectify the situation. We also observed during our visit to Turner ward that the fire escape route at the end of ward had equipment close to the exit which could hinder patients and staff leaving quickly.
- We checked resuscitation trolleys in each of the areas we visited. On Simpson ward we noted the trolley had not had daily checks completed on four days during the previous month. On Turner ward we found the resuscitation trolley had not been checked for the preceding three days. A resuscitation trolley contains all the equipment that may be required in an emergency situation, for example a cardiac arrest. On the occasions where checks had not happened staff on the unit would not be assured that all the equipment necessary was suitably maintained or available to them in an emergency situation.
- During our inspection a mattresses audit was underway. The purpose of this was to identify which mattresses were being used and to look at how mattress selection was being completed by the nursing staff. At the time of our inspection pressure relieving mattresses were hired into the hospital based on the needs of the patient.
- The coronary care unit was spacious and well-kept and provided a pleasant calm environment for patients. The Ricky Grant oncology day unit had a well thought out, patient influenced design. The environment was bright and open and supported the efficient and safe running of the unit.
- Nurses told us that any equipment they needed was readily available and provided by the hospital's medical device service. Such equipment included medicine pumps, syringe drivers or air mattresses used to support those at risk or with a pressure ulcer. Specialist wards such as the respiratory ward had access to the specialist equipment needed to provide this care, such as ventilators. The cardiology centre was well equipped with all the necessary equipment needed to provide specialist care.
- All of the equipment we checked had been serviced and maintained in line with their schedules, including portable appliance testing (PAT) where required.

Medicines

- Arrangements for managing medicines and medical gases did not always keep people safe. On Turner ward, we found that rescue medication, to be used in the event of a dangerously low blood sugar, was past its expiry date. This was brought to the ward managers' attention who immediately ordered new stock from the hospital pharmacy and completed an incident report. We were told this should have been checked as part of the nightly checks of medication on the ward. Upon looking at these records for the preceding 10 nights, three checks had not been completed.
- On Turner ward some intravenous fluids were found to be past their expiry date. These fluids were the only ones of their type in stock on the ward, and this presented a risk they could be administered to patients. Staff could not be assured of the safety of fluids administered after their expiry date. We were told by staff there were clear processes to check expiry dates prior to administration, but the processes for checking stock on a regular basis were not being followed.
- The medicines refrigerator on Turner ward had two thermometers. The nurse in charge told us they would only record from the lower reading thermometer, as per guidance from the trust's pharmacy. Medicines required to be stored in refrigerators can become ineffective if they do not remain within specific temperature ranges. The daily checking sheets showed the temperature had been recorded on the day of our visit. The current reading was 4°C. There was no maximum or minimum temperature recorded, as per pharmaceutical guidelines. On checking the previous records, we could only locate records until the end of December 2016; no records were available for the four months prior to our inspection. We were told the refrigerator temperatures had been monitored and recorded by the pharmacy technician until December 2016. This had been added

to the night duty checklist at the start of May 2017. We asked the nurse in charge if they could access the policy on refrigerator temperature monitoring, but they were not able to find this on the intranet.

- Medicines were stored in locked trolleys and locked cupboards and only authorised staff had access to these.
- During medicines rounds, nurses wore red tabards which informed others they were administering medicines and should not be disturbed. This was good practice and enabled these staff to concentrate without being distracted.
- Medicine administration records were not always completed fully by doctors completing prescriptions. In all of the records we sampled, signatures were illegible and the prescriber could not be tracked using the prescription charts.
- We saw effective reconciliation of medicine administration records by pharmacists which provided assurances about the use and administration of medicines. The purpose of medicines reconciliation is to make sure the right patient gets the right medicine, in the right dose and at the right time, as well as reducing the risk of medicine errors occurring when the care of a patient is passed from one care setting to another.
- Controlled drugs were stored securely inside double locked cupboards. These were clearly labelled and reconciled in a book containing stock levels. When administered, controlled drugs were signed for by two nurses.
- On the emergency admissions unit (EAU) some patient group directives (PGD) were in place. A PGD, signed by a doctor and agreed by a pharmacist, can act as a direction to a nurse to supply and/or administer prescription-only medicines to patients using their own assessment of patient need, without necessarily referring back to a doctor for an individual prescription. For these medicines, correct processes were in place for their use, and they had been reviewed regularly.
- Oxygen cylinders were available for patient transfer and these were seen to be stored in a safe and secure manner.
- A multidisciplinary antimicrobial stewardship team were responsible for ensuring clinicians, pharmacists and nurses adhered to the trust's antimicrobial prescribing policy. Through a system of audit the team monitored compliance with trust policies. In 2016 these showed an overall performance of between 72% and 100% within the medicine division. Where compliance fell below the target of 90%, a ward would be audited weekly until their performance improved. The data we saw suggested this was an effective measure of improving compliance with trust policy.
- The trust had recently introduced an updated insulin self-administration assessment for those patients who wished to continue administering their insulin whilst in hospital. Staff were able to follow the checklist to identify if the patient was able to continue and actions needed to make sure they were able to do this safely. The tissue viability service had introduced a trust-wide dressing formulary to ensure all staff on the hospital wards and community were using the same dressings for continuity of patient treatment.

Records

- People's individual care records were not always written or managed in a way that kept people safe. We looked at the care and medical records of 27 people. We found nursing assessments and risk assessments were not always completed consistently. Nursing assessments described the care needs of patients. Risk assessments aimed to ensure that potential harm was avoided, for example identifying a patient's risk of developing a pressure ulcer. This meant staff providing care could not be assured risks had been taken into consideration when care plans were designed for patients. The lack of nursing assessments meant the nursing needs of patients were not easy to establish for nurses who had not met patients before, for example bank or agency nurses.
- On Turner ward we looked at three sets of patient records and found none of them had risk assessments completed in relation to falls, nutrition or pressure ulcers. We were told staff did not have time to complete assessments fully because the ward was busy. On Allerton ward we looked at two sets of records. We found risk assessments had been completed but not reviewed for five weeks.
- Medical notes were kept alongside nursing notes for current admissions, with previous medical notes stored in a main file. Medical notes were signed, but these signatures were often not legible. This meant it was not always possible to identify who had completed the record. A division action plan identified that doctors

would be provided with a stamp containing their name and GMC registration number to add to the end of each record entry. We only saw these in use in two sets of notes we looked at.

- Staff could not be assured of the security of patient information. Records were not stored securely in any of the areas we visited. Medical notes of patients were stored on shelves, sometimes behind a reception desk, and sometimes on trolleys away from the reception areas. On the emergency assessment unit four (EAU4) records were stored on a shelf in an unmanned area frequented by patients. We brought this to the attention of managers at the end of our inspection and they were immediately moved to behind the main area of the ward which was manned by a ward clerk.
- Wards we visited used display screens in or around the reception area which provided up to date information on the status of patients. These screens were not always locked or obscured after use and the size of these screens meant confidential personal information was clearly available to anyone in the vicinity. The information displayed used symbols and abbreviations wherever possible, although some personal information was visible.We were told that as screens were in use by clinicians at all times, it would be inefficient to lock the screen after every use.
- Colour coded weekend review sheets were available for use by doctors who reviewed patients on a Friday. We saw these in use and found a doctor completed a summary of the patient so a colleague caring for that patient at the weekend could identify all of the key points about their care and treatment.
- Cardiology patients had their records electronically "tagged". This meant the cardiology team were automatically alerted if the patient was readmitted, allowing for swifter treatment at that time.
- Ward managers conducted monthly records audits looking at the completion of patient records. These looked at indicators such as general standards of note keeping, management of deteriorating patients' documents, quality of discharge information and whether a venous thromboembolism assessment had been completed fully. Between June 2016 and April 2017, the completion rate of these audits varied, with only 55% of medical wards in November 2016 returning an audit. Performance for returned audits scored consistently highly at above 90%. However, in months where returns were poor managers could not be assured of the quality or consistency of record keeping across the division.

Safeguarding

- There were safeguarding systems, processes and practices in place which aimed to keep people safe and these were communicated to staff. We found staff of all levels demonstrated a thorough understanding of adult safeguarding policies and procedures. These situations ranged from ensuring vulnerable patients could cope when they were discharged, to addressing issues concerning patients who may be at risk of abuse.
- Nurses spoken with across the medicine division confidently described their roles in identifying vulnerable adults at risk, and reporting these concerns. We were given an example where a patient confided in staff regarding potential financial abuse and this was taken forward and reported. Staff spoke highly of the support they received from the safeguarding lead should the need arise, and were able to ring for this support when it was needed.
- Support was provided to staff on an "as required" basis by the safeguarding adults leads. There was not a formal programme of safeguarding supervision available to staff. We were told this was because the safeguarding team did not have capacity to provide this. The emphasis was therefore on a staff member to seek support when it was felt necessary. This system depended on the staff member identifying when further advice, support or training may be necessary.
- Safeguarding concerns were added to patient notes meaning that should they be readmitted staff could find this information easily.
- Safeguarding training was delivered by the safeguarding team; routinely at induction and by request for whole teams if it was needed. Additionally, staff were able to access an e-learning module on safeguarding.
- The trust could not be assured all staff had the safeguarding knowledge required to keep patients safe. Not all staff within the medicine division had achieved safeguarding adults training in line with trust requirements. The trust's target for completion of adult safeguarding training was 90%. However, only 53% of staff in the medicine division had completed level three training. For staff requiring level two training, 89% were

up-to-date. Completion of safeguarding children training also fell below trust requirements of 90%. The medicine division had a completion rate of 75% for this training at level two.

Mandatory training

- Mandatory training compliance fell below the trust's internal targets in all areas with the exception of Equality, Diversity and Human Rights training. The trust had a minimum staff training target of 85%for infection control, fire safety, health and safety, conflict resolution, moving and handling and equality and diversity. For information governance this target was 95%. Completion of training for fire safety, health and safety and conflict resolution came close to the targets with 82%, 84% and 79% respectively. Completion of moving and handling training stood at 77%, with information governance training completed by 77% of staff. We did not see any action plans which addressed this shortfall.
- We were told the majority of mandatory training was made available as e-learning as opposed to classroom based training. Staff told us it could be difficult to find the time to be able to complete this training during their working hours as they were so busy. The system had been improved so it was easier to access. The improvements included the ability for staff to be able to access the system off-site, from home. This often meant staff were completing training in their own, unpaid time. Ward managers told us that where possible, they allowed time for staff to complete training during their working hours but this wasn't always possible. A number of staff told us they still experienced problems accessing the training system.

Assessing and responding to patient risk

- Patients had timely access to care and treatment. We saw that upon admission, patients were reviewed by a consultant within four hours during the week, and within 12 hours outside of regular hours. This had been improved by a recent reconfiguration of consultants' hours into seven day working patterns.
- The trust had a process in place which aimed to ensure comprehensive risk assessments were carried out for patients, with management plans that described how these risks could be managed. Staff used the National Early Warning Score (NEWS) system to identify patients who were deteriorating. We saw this recorded and completed regularly in all the notes we looked at.
- The risk of venous thromboembolism (VTE) was assessed for all patients whose records we looked at. This assessment included the prescription of preventative medicine to reduce the risk of blood clots to immobile patients.
- We observed the use of tools to assess the risk of malnutrition in patients and found these to be completed for patients with increased risks. These patients were then monitored more closely for their intake of food and fluid. Support was sought from the dietetics team, as well as the hospital kitchen, to ensure as many actions as possible were put into place to minimise the risk.
- All patients admitted had an assessment of their risk of developing a pressure ulcer. This informed how they were cared for during their stay, including the use of pressure relieving equipment and treatment of any existing pressure areas. A tissue viability lead nurse was also available to offer support to ward staff to manage the care of patients with increased risks. We saw staff completed a skin care bundle and risk score for every patient within two hours of admission.
- Staff on care of the elderly wards used a risk assessment booklet to document routine mobility and bed rail assessments.
- We observed a number of multidisciplinary meetings during our inspection. At these meetings we saw other risks were routinely discussed with plans made of how these could be managed. These included the social risks to patients when they were discharged, and support for families and carers.
- A daily morning safety briefing occurred on acute medical wards, which enabled night staff to brief day staff on any patients who had deteriorated or experienced difficulties overnight. Staff included new admissions, urgent medical reviews, falls incidents, pressure ulcer risks and patients being cared for under barrier nursing practices in the discussion. We also saw the use of "night diaries". These documents provided a clear record of patient activities during the night and provided a clear record of nocturnal needs for patients. This enabled their care to be planned to take account of these needs and maintain their safety. An evening handover occurred at the start of the night shift where each patient was discussed and developments in their treatment and condition handed over.
- Staff on medical wards used a system of intentional rounding. This process involved the regular (two hourly)

recording of key safety checks, such as if the patient could reach the call bell or if they were wearing non-slip slippers. Assessments of continence, pain and comfort, hydration and positioning in bed were included. We saw this process was designed to reduce the number of preventable incidents in ward areas. However, we saw there were gaps in the completion of this document in all areas we visited.

- The endoscopy unit used a modified version of the World Health Organisation (WHO) safety checklist and we saw evidence on these that staff held a team briefing before each list. The National Patient Safety Agency recommended this process be used for every patient undergoing any surgical procedure. It involved a number of safety checks designed to ensure staff avoided errors and patients avoided harm. The trust audited the completion of this checklist and results showed an overall compliance of 90% between April 2016 and March 2017. We were told this process was well embedded and used as a safety system.
- Patients had weekend plans in place to allow for the continued and consistent provision of their care out of hours. The plans contained information to help staff manage risk and provide treatment. These plans were updated each time there was a change either in their condition, their treatment or both. An audit of weekend plans in November 2016 showed that across medical units 77% of patients had weekend plans in place.
- Members of nursing staff for each ward were appointed as tissue viability champions. They attended regular meetings run by the tissue viability service. The role of these champions was to provide additional advice and support to their colleagues. Each ward and unit had a folder from the tissue viability service with advice and support about wound management and pressure relieving equipment.
- On the care of the elderly wards assistive technology was used in the care of patients with dementia. Assistive technology is a collective term for devices that can enhance the physical, sensory and cognitive abilities of people with disabilities to help them function more independently. A nurse gave an example where a patient with dementia was admitted and said to need one to one staffing support to maintain their safety. Following an assessment, the team on the ward provided pressure pads which alerted staff if the patient left their room. This meant the patient could be provided with privacy and independence but staff could be assured of their whereabouts and safety.
- On Allerton ward a system within the electronic record was being trialled that alerted staff when risk assessments were due to be reviewed. This provided a list for staff and informed them when it had been completed. The purpose was to make sure patients risks were assessed and reviewed to meet their assessed needs.
- Changes had been made to how the oncology chemotherapy team made referrals to the diabetes service following a high number of incidents where diabetic patients receiving chemotherapy had suffered hyperglycaemic episodes (high blood sugars). A new referral pathway was designed which involved early identification of those patients at risk and involvement of the specialist diabetes nurses earlier prior to their chemotherapy. Patients were supported by the diabetes specialist nurses and treatment plans were devised to reduce the risk of hyperglycaemic episodes.
- Senior staff on Cheetham Hill ward told us they had a comparatively high number of falls on this ward due to the nature of the patients they cared for. However, mitigating actions were in place to minimise these. For example, patients who needed close observation were placed close to the nursing staff, non-slip flooring had been fitted and pressure mats were in use. Pressure mats alerted staff when patients stood on them and therefore ensured they were aware when vulnerable patients were up and about.

Nursing staffing

- Staffing levels in the areas we visited were sufficient to keep patients safe. Staffing levels varied in different areas dependent on the acuity of patients cared for. We were told staffing levels were planned and reviewed monthly by medicine division leaders. A staffing planning tool, known as the Safer Nursing Care Tool, was used to establish the exact levels of registered and unregistered nursing staff required to care for patients on wards with various specialisms. The safer nursing care tool is an evidence-based tool that enables nurses to assess patient acuity and dependency, incorporating

a staffing multiplier to ensure nursing establishments reflect patient needs. In recent months, this tool had been used to increase nursing numbers on Midgely ward to account for the increased patient needs on this ward.

- We were told nursing staff vacancies had reduced in recent months, partly due to the closure of other areas within the trust, and partly due to successful external recruitment. This reduced vacancy rate had resulted in a reduced reliance on agency nurses, and the increased deployment of consistent bank staff in certain areas. Bank staff told us they tended to work on the same two or three wards and this made them feel more confident in their role. It also enabled them to keep abreast of developments and changes in specific ward areas.
- Nurses told us that when shifts were fully covered they felt staffing levels were safe. Although shifts were very busy, nurses felt they could deliver safe care to their patients. On the two emergency assessment units (EAUs), there was an agreement where staff were shared to ensure sufficient staffing if numbers were unequal. This allowed both wards to be responsive to changing situations.
- When necessary, for more dependent patients, staff were able to access additional staffing. For example, if a patient had been identified as requiring staffing on a one to one basis, this could normally be facilitated by contacting the trust nursing bank. During our visit, a patient at high risk of falls was identified by night staff. By 10am, an additional healthcare assistant was made available to work with the patient on a one to one basis, to minimise the risk of a fall.
- In total, the medical services division employed 545 nursing staff, of which 39% were unregistered; for example healthcare assistants. We saw evidence planned levels of staffing were achieved in all wards within the medicine division with some overprovision that was required for more dependent patients.
- On the wards we visited we saw a combination of both registered nurses and healthcare assistants. The ratio of these varied depending on the ward and time of day. For example, on Cheetham Hill ward there were equal numbers of registered and unregistered nurses working in pairs to care for patients. On the acute medical unit, which cared for ambulatory patients, there were also equal numbers of health care assistants and registered nurses.
- We observed safer staffing levels were displayed at the entrances to the wards. We visited Turner ward during our inspection and noted there were the correct levels of registered and unregistered staff on duty. Senior staff told us they regularly had bank staff on their night shifts but they always had two of their own staff on duty to maintain continuity of care and they were able to support the bank staff. Staff told us they had a great team and all helped each other.
- On all of the wards we visited, handovers occurred twice a day; once in the morning at around 7.30am and once in the evening at around 8pm.

Medical staffing

- Medical staffing levels and skill mixes were planned so that patients could receive safe care and treatment at all times. The trust had recently implemented a programme of reconfiguration which looked at the provision of consultant cover out of hours, especially at weekends. This reconfiguration had resulted in consultants being present and available each day throughout the weekend to admit patients and review particularly ill patients. They also provided extra support for more junior doctors who worked during these times. In addition, the way the rota at weekends was designed, ensured the available consultants were of differing specialties and were therefore able to offer specialist support during this time.
- We were told the consequence of additional consultant cover at weekends was a lesser presence during the week. In endoscopy, for example, this had an effect on the number of lists that could be completed in the week. We were not aware of any plans to address this.
- We looked at the junior doctor duty rota for general medicine. During the working week planned staffing levels were one registrar on call, plus an additional four middle grade doctors across medical wards. Evening clerking, between 5pm and 9.30pm, was completed by two middle grade doctors with an additional middle grade doctor working a late shift until midnight. Overnight, medical cover was provided by a registrar on call, together with two middle grade doctors. Each ward also had two foundation grade doctors. We were told by front line nursing and medical staff that junior doctor numbers were "just about adequate".
- For the week of our inspection we looked at the medical staffing rotas. There were gaps in this rota, which were covered by the trust employing two long term locums. As these were long term, these doctors worked

seamlessly within the team. Doctors were all very busy, however were coping with their workloads and were supporting each other. We saw from the rota that planned levels of medical staffing were maintained.

- A team of cardiologists covered the cardiac care unit, four of whom covered an on call rota. In addition to ward cover, these doctors also carried out angioplasties, and so their workload was shared between both roles. Nurses within the cardiology unit told us they felt medical cover was sufficient to support them and the patients safely.
- The acute medical unit, which provided ambulatory care to patients, was a consultant-led service. Consultant cover on this unit was shared with other areas of the hospital, meaning a consultant did not arrive on the unit until 2pm. The unit was open from 8.30am and staffed by junior doctors in addition to consultant cover in the afternoon. This meant a patient arriving in the unit in the morning could wait until 2pm in the afternoon if they needed a consultant opinion on their care. Due to the nature of the unit, these patients were not felt to be at risk due to this wait. In emergency situations the unit could call for consultant support if needed. However cover by more junior doctors before 2pm was felt to be sufficient. We were told the unit had funding to open seven days a week. However, due to a shortage of medical staff it was not able to open at weekends.
- Staff on wards that were used to accommodate medical outlier patients told us they had no problems getting these patients reviewed by medical doctors when required. Medical outliers are patients who require input from the medical teams but due to bed availability are being cared for in another speciality.
- Across the medicine division there was one consultant vacancy, being covered by a locum consultant at the time of our inspection. In addition, one consultant was on maternity leave. There were three vacancies within the division for registrar doctors, which were being covered by locum positions.

Major incident awareness and training

- The trust had a major incident plan which was available to staff in all areas on the intranet. Staff told us they knew where to locate this information, and it was seen to be available as a hard copy in the ward areas we visited. Staff had not received training in the use of the major incident plan.
- We looked at fire procedures and safety arrangements in the areas we visited. Each area had a fire warden, responsible for ensuring daily safety checks were completed. The logs to record these were not always completed fully.
- On Cheetham Hill ward we saw fire evacuation equipment was in place. However, staff on duty at the time of our visit were not confident in its use. On Simpson ward, we found a number of checks of safety equipment were overdue. Fire doors, emergency lighting, smoke detectors, and call point checks were all overdue for testing. In addition, the monthly simulation of failures had not been completed and it was unclear when this had last been carried out. There was also no completion of the general fire audit tool available to view. The fire exit on the Torbay Assessment Investigation and Rehabilitation Unit (TAIRU) was blocked during our visit. This was brought to the trust's attention at the end of our visit and the obstacles were removed.
- We met with a senior member of staff who had responsibility for overseeing fire safety. Improvements that had been implemented included assigning fire wardens to each ward. These staff had responsibility to lead the team in the event of a fire. In all acute areas of the hospital, safety, security and emergency planning boards were in place. We were shown one of these boards outside a medical ward. They contained action cards, a fire safety log book, a tabard for the senior member of staff to wear and health and safety information. On this board was a place to write who the fire warden was. We were told there were plans in place to audit these boards using a set criteria and questions. This had not started at the time of our inspection. Trust action plans stated monthly audits of the fire safety log books would be taking place. We were provided with a specimen of these logs which demonstrated that on TAIRU these checks had been completed.
- We checked the fire safety log book on Cheetham Hill and Turner wards and found they had not had monthly checks completed in the two months prior to our visit. This meant there was no assurance the equipment provided was readily available and ready for use.
- Security staff were available on site 24 hours a day to support staff. They provided support to staff in incidents where patients or visitors were displaying challenging behaviour.

Medical care (including older people's care)

Are medical care services effective?

Good

We found the issues identified during our inspection in February 2016 that caused effective to be rated as requires improvement had been addressed.

We rated effective as good because:

- There was effective and consistent use of evidence-based practice for patients in the medicine division.
- Risk assessments for a variety of conditions were completed routinely and used to inform care.
- Effective processes ensured patients were reviewed by consultants in line with national guidelines.
- Multidisciplinary working was truly embedded throughout the division, both internally and externally to the hospital.
- Consultant cover at weekends had been greatly improved by reconfiguration of working patterns, with improved patient outcomes as a result.
- The trust had significantly improved its performance in national audits of stroke care, and diabetic foot care, by responding to outcomes from previous audits.
- The trust had implemented the Faculty of Pain Management's 'Core standards for pain management'. These standards describe the actions to be taken to ensure that patients receive effective and evidence-based care to manage their pain.
- Between July 2016 and March 2017, the trust exceeded national targets for the numbers of patients spending at least 90% of their hospital stay on dedicated stroke wards.

However:

- The completion of discharge summaries was below trust targets.
- Audits against evidence-based care, completed in 2016, demonstrated the trust performed below national targets for compliance with recommended courses of action in a number of areas. We did not see how this information was being used to improve practice during our inspection.
- Performance in the National Diabetes Inpatient Audit was in the lowest quartile nationally.
- Assessments of patients' risk of malnutrition were not consistently recorded.

Evidence-based care and treatment

- Evidence based guidance and best practice was used to develop policies and procedures. This included management and prevention of pressure ulcers, and other risk management tools. These guidelines also included the management of a variety of conditions involving heart failure, kidney disease, diabetes and gastrointestinal illnesses.
- Pathways describing the management of various conditions were based on guidance from the National Institute for Health and Care Excellence (NICE). This ensured patients had their needs assessed and care delivered in line with evidence-based guidance standards and best practice.
- All patients we saw had had a venous thromboembolism (VTE) risk assessment completed upon admission with appropriate preventative medication prescribed where necessary. This was in line with the best practice guidance of NICE. A venous thromboembolism is the formation of blood clots in the vein, and patients who are immobile for sustained periods of time are at greater risk of developing these without intervention.
- Processes for recognising and responding to deteriorating patients followed NICE guidance
- The trust used a sepsis management pathway. This was a comprehensive screening bundle which ensured staff closely observed patients at risk of developing sepsis. This pathway was based on NICE guidelines and provided clear directions for staff in the care of these patients.
- The medicines division took part in a programme of audit to monitor their performance against key evidence-based standards. These included follow-up imaging for patients with pneumonia, testing for vitamin D deficiency in patients over 65, diagnostic testing for Parkinson's, and treatment of patients with liver cirrhosis. In 2016, all of these audits demonstrated the trust performed below national targets for compliance with recommended courses of action. We did not see evidence of how this information was being used to improve practice during our inspection.
- We also looked at the outcomes of audits relating to end of life care, diabetic foot care, patient falls, the management of chronic obstructive pulmonary disease,

and the management of patients with pacemakers. Where outcomes indicated sub-optimal performance, these audits were accompanied with action plans to modify practices and improve performance. At the time of our inspection it was too early to see the effects of these action plans.

- Consultant physicians and consultant surgeons worked together on Allerton ward to ensure patients being treated for inflammatory bowel disease were cared for by medical and surgical physicians with evidence-based practice from their respective specialties.
- Physiotherapists on care of the elderly wards used the elderly mobility scale to assess risks associated with moving patients, which was used to plan their physiotherapy programme.

Pain relief

- Patients we spoke with in all areas told us they were asked regularly about their pain, and were offered pain relief when they needed it. We saw patients had pain relief prescribed both regularly and as required.
- The trust had implemented the Faculty of Pain Management's 'Core standards for pain management'. These standards describe the actions to be taken to ensure that patients receive effective and evidence-based care to manage their pain.
- The trust had a specialist pain team that staff could refer to should the need arise. This team was led by a consultant who was a member of the Faculty of Pain Management. This service was available 8am to 6pm, Monday to Friday.
- We saw inconsistent recording of pain scores in patient records. We were therefore not assured of consistent practices around the management of pain.

Nutrition and hydration

- Not all patients had their nutritional needs assessed on admission. The trust used the Malnutrition Universal Screening Tool (MUST); however we found this was not always being used by staff.
- We saw that where there were concerns around hydration, fluid monitoring charts were in place to observe this, and food charts recorded the intake of food in vulnerable patients.
- Dietitians were available to support ward-based staff to meet the needs of patients with risks associated with poor food intake.
- There was a supply of supplements and snacks that could be given to patients in addition to regular meals. In addition, staff told us they were able to ring the kitchen and request food outside of the planned menus and this was always provided.
- We were told that for patients who required it, such as those with dementia, finger food could be ordered from the kitchen. Evidence has shown that patients with dementia often maintain a better intake of food if they are able to eat without cutlery.
- We saw there were plentiful supplies of tea, coffee and water available to patients and this was offered regularly.

Patient outcomes

- Between November 2015 and October 2016, patients at the trust had a similar expected risk of readmission when compared to the England average.
- Patient outcomes were improved by the use of national audits to monitor and deliver care, and staff sought accreditation from specialist bodies to demonstrate the high standards patients could expect. For example, the endoscopy suite was accredited for gastrointestinal endoscopy by the joint advisory group (JAG). This accreditation demonstrated the effectiveness of the endoscopy service. JAG measures quality and safety indicators, including outcomes.
- Torbay hospital took part in the quarterly Sentinel Stroke National Audit Programme (SSNAP). This is a NICE accredited audit programme, carried out by the Royal College of Physicians. The Sentinel Stroke National Audit Programme aims to improve the quality of stroke care by measuring both the structure and processes of stroke care against evidence-based standards. On a scale of A-E, where A is best, the trust achieved grade D in the audit of the first quarter of 2016. This was the same grade they achieved in the previous quarter. At the time of our visit, this had improved to a B. We were told this improvement had been achieved through the work of a dedicated strategy group, and the introduction of a governance framework looking specifically at SSNAP performance. This work had resulted in the recruitment of two consultants to help within the stroke unit. Furthermore, a visit to a unit in another hospital had resulted in learning for the team.

This meant patients received improved care, particularly around the timeliness of key interventions and treatment following a stroke. Ultimately this improved patients' outcomes.

- Between July 2016 and March 2017, the trust exceeded national targets for the numbers of patients spending at least 90% of their hospital stay on dedicated stroke wards. The national target was for 80% of patients to spend this amount of time on specialist wards. The trust achieved between 82.9% and 94.9% during this period.
- The trust performed in the lower quartile of the National Diabetes Inpatient Audit (NaDIA). NaDIA measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital, and aims to support quality improvement. The 2016 NaDIA identified that of the patients with diabetes treated at Torbay hospital, 74.3% reported they were satisfied or very satisfied with the overall care of their diabetes
- The trust was among the top performing trusts for diabetes foot care. The diabetes foot care audit required services to measure their performance against NICE clinical guidelines, monitor adverse patient outcomes and compare their performance with peer units. In 2015 the trust had performed amongst the worst in the south west in relation to amputation rates. However, in 2016 this had improved significantly and the trust placed in the top performing trusts. Staff said this improvement was due to their weekly foot clinics being attended by a range of staff, allowing for effective joined-up working.
- The trust was performing better than in the previous year in the treatment of patients with lung cancer. The National Lung Cancer Audit looks at the care delivered during referral, diagnosis, treatment and outcomes for people diagnosed with lung cancer and mesothelioma. The proportion of patients seen by a cancer nurse specialist was 94.6%, an increase from 80% the previous year. The national aspirational standard was 80%. The proportion of patients with confirmed lung cancer receiving surgery was 13.1%, an increase from 12% in the previous year. The proportion of fit patients with advanced lung cancer receiving chemotherapy was 45.1%, up from 37.3% in 2015. The proportion of patients with small cell lung cancer receiving chemotherapy was 90%, an improvement from 75% in 2015. The one year relative survival rate for the trust was 42.1%.
- Length of stay for medical patients in the trust ranged between five days in November 2016, and just over four days in March 2017. This reflected an improved performance over this time.
- Doctors of all grades contributed to a rolling programme of clinical audits across all medical specialities. The audits covered a wide range of topics including blood transfusions at weekends and improvements in the heart failure service. Junior doctors presented the findings of audits at a weekly meeting and conducted re-audits to ensure learning was embedded in practice.
- The stroke service held quarterly multidisciplinary case discussion meetings. These meetings discussed three cases from the period, and looked at whether these could have been managed better. This demonstrated an embedded process of localised evidence-based learning which influenced practice.

Competent staff

- Across the medicine division, 84% of staff had an up to date appraisal against a target of 90%. Nursing staff told us their appraisal was a useful process where they felt supported to develop in their role. Appraisals were seen as an opportunity to identify learning opportunities for staff at all levels.
- Staff had the right qualifications, skills, knowledge and experience to do their job. Unregistered nursing staff told us their induction, both classroom and ward-based, had given them the basic skills they needed to begin their role. On an ongoing basis, a process of competency assessments and on the job learning ensured they developed their skills. Newly qualified registered nurses completed a period of preceptorship when starting their new roles. This involved being allocated a 'buddy' to go to for support and advice, being given regular opportunities to meet with ward leaders and to evaluate progress in the role.
- A number of ward managers and matrons had been promoted to these roles from within the trust and it was felt this was beneficial to them in their role. We were told having previously worked in front line roles gave them a greater understanding of the challenges faced by front line staff, together with the ability to step in and support staff if the need arose.
- Ward managers were responsible for new staff inductions. Staff who were new to the trust completed an induction process that introduced them to the organisation and delivered mandatory training.

- From January to March 2017 the trust had a "'call to action'. This term describes a process aimed at driving efficiencies in a short space of time. During this period, most face to face training had been cancelled. Managers told us they had planned for this by ensuring staff achieved as much training as possible prior to January 2016, so they were up to date with their training requirements in this time. Some nurses we spoke with understood the reasons behind the decision and did not feel it had affected their ability to carry out their roles. Other staff felt concerned about this lack of training opportunities during this time, and didn't understand why the decision had been taken.
- Nurses working in specialities had received training in role-specific subjects. For example, 95% working on medical wards had received training on dementia. These staff achieved the 'purple angel' status. This status tells the public that staff have achieved a level of competence that better improves their ability to work with patients with dementia. Nurses working within cardiology undertook an annual basic cardiology course.
- All except three junior staff working in the respiratory ward had undertaken training on non-invasive ventilation, which equipped them to be able to care for patients with acute respiratory needs. Staff also told us they felt able to request additional training and it would be considered if it was relevant to their role.
- All nurses working on the Ricky Grant unit and Turner ward had completed, or were in the process of completing, a course about chemotherapy. This aimed to ensure they had the appropriate skills to meet the needs of their patients.
- Plans were in place to provide breakaway training for security staff as they were often called to support staff when patients were displaying challenging behaviour and aggression. This training was designed to provide staff with the skills to manage patients displaying challenging behaviour. This could include those who were living with dementia or learning difficulties or mental health issues.
- Junior doctors received support from senior doctors in preparation for their Practical Assessment of Clinical Examination. Completion of this examination enables junior doctors to enter higher specialist training.
- Poor or variable performance was managed in accordance with the trust's policy. This policy gave clear guidance to managers with responsibility for staff management. Managers told us they were confident in using the policy to manage staff performance with further support from the trust's human resources department if required.

Multidisciplinary working

- All necessary staff, from across different teams and services, were routinely involved in the planning and delivery of patient care and treatment. This practice began at the start of each day with a multidisciplinary meeting. This meeting discussed all patients on a ward, and was led by the doctor or nurse with responsibility for that patient. Also in attendance at these meetings were physiotherapists, occupational therapists and discharge coordinators. This method was an efficient way of ensuring joined up care for a patient, where a plan of action could be formulated to be carried through for that day. Feedback from nursing, medical and therapy staff was that this process worked very well at avoiding unnecessarily long stays in hospital, and optimising the treatment given to patients during their stay. Nurses and therapists had close links with their community colleagues, which enabled a smooth transition from acute to community based care and was a key discussion in these meetings.
- We observed good integration between therapy and nursing staff, with nurses and healthcare assistants supporting physiotherapists and occupational therapists in their work. We were told that at weekends healthcare assistants supported patients with rehabilitation activities designed by therapists.
- On Turner ward we observed a handover between the ward sister, junior doctors and an occupational therapist. All patients were discussed, including investigations and plans for discharge. This meant all staff involved in the patients care were up to date and knew if their input was needed.
- The matron in charge of the gastrointestinal wards had brought all the specialist nurses and consultants together on the same floor. This included liver nurses, colorectal nurses, colorectal surgeons and bowel screening nurses. The purpose of this was to improve the discussions between all teams when they were caring for and treating the same patients with complex needs.
- An effective computer programme on the trust's shared medical drive mapped the day's admissions. Doctors and nurses could track all the patients at a glance.

Anyone was able to input data and update the patient journey through the system. The time log and time lapse functions highlighted how long a patient had been in a particular place and also if they were going to breach targets for length of stay. The junior doctors and consultants on duty monitored this very frequently. If a particular area was under pressure, doctors in less busy areas would go to help out, for as long as was needed to relieve the pressure.

- All medical wards we visited had access to daily input from a dietician and the speech and language team where necessary. Staff could readily obtain the assistance of social workers when needed.
- The trust's discharge policy described the processes that should be followed for an effective discharge. This included information about preferred times of day, together with the support that should be ensured to secure a safe discharge for more vulnerable patients. The policy emphasised the decision to discharge a patient should be made by a multidisciplinary team and these discussions should begin at the point of admission. We saw this in practice and the collaborative approach provided a safe mechanism for discharge.
- We met with staff from the complex discharge team. This team facilitated discharges for patients with complex needs. This included patients who required a placement in a care home or domiciliary care packages in their own home. The team consisted of social workers and liaison nurses. They supported the staff on the wards by assisting in arranging the patient's ongoing care needs. In addition, a discharge team worked with the wards to help to arrange discharges for patients who did not have complex needs. Plans were in place to join these two teams.
- The trust had a psychiatric liaison service which consisted of a consultant psychiatrist and nurse practitioners. There was an out of hours service which was run by a night nurse practitioner who could assess patients and then develop an appropriate care plan. The out of hours service also had a junior doctor and an on call consultant.
- During our inspection the hospital had declared they were at 'OPEL four'. OPEL stands for operational pressures escalation level and describes the actions a trust is expected to take to manage capacity pressures. OPEL four is the most severe level. We attended some of the operational meetings and witnessed exceptional examples of multidisciplinary working as the trust worked together to make sure all patients received safe care. The hospital and community worked together to pool their resources to help free up beds in the hospital for the patients waiting in their emergency department. This had the effect of reducing the level to OPEL three within 24 hours.

Seven-day services

- The medicine division had recently reconfigured consultant working patterns to increase levels of senior medical cover at weekends. This resulted in a total of four consultants with different specialties available to patients over the weekend. As well as providing specialist care to patients, consultants could support junior doctors outside of regular hours. As a result, the number of discharges occurring at weekends had risen, improving patient flow during this time.
- The trust was meeting targets for first consultant review at all times. Feedback from staff about the effects of this were that patients benefitted from a specialised care plan being started sooner. Patients at weekends were able to receive the services of a consultant to review their care if it was needed. However, this was generally reserved for more sick patients and new admissions.
- The hospital operated a system known as 'Hospital at Night' and 'Hospital by Day'. This system acted as an answering service on behalf of the junior doctors. Out of hours staff could call a single number to alert junior doctors of a patient needing medical review. The aim of this system was to reduce the number of unnecessary calls received by junior doctors out of hours, and to organise work efficiently, for example by ward or area of the hospital.
- The trust had addressed an issue around the care of patients at weekends. In order to manage the reduced level of overall medical cover during this period, medical patients each had a weekend care plan which described the plan for treatment of patients over the weekend period. We saw that all except two of the sets of patient records we reviewed contained a weekend plan for patients. These were clear, dated and signed. Junior medical staff reported this had greatly improved their ability to provide consistent care during weekend hours.
- Changes to the oncology service were due to take place in June 2017 to meet patient demand. The planned

changes would ensure specialist nurses would be available on site six days per week with an on call telephone service for Sundays to provide advice and support to staff.
- Physiotherapy staff were available seven days a week on acute medical wards. Outside of daytime hours a respiratory physiotherapist was available on call. Occupational therapists covered a five day week. It was acknowledged that this service would benefit from seven day cover, and this had been piloted for three months in 2016. At the time of our inspection, the options for making this a permanent seven day service were being considered.
- On call services for dietetics, radiology and microbiology were available seven days a week.
- Pharmacy support visited the wards daily between Monday and Friday and was available on call outside of these hours. They conducted medicines reconciliations, prescription chart reviews, stock replenishment and supervision of nurses during medicine rounds.

Access to information

- Information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way. Staff on the emergency admissions units (EAUs) told us patient notes and information was readily available when they needed it. Patient records were kept both electronically and in paper format. We saw vital information was available in both formats.
- An electronic patient tracking system enabled staff to identify where a patient had previously had a safeguarding concern raised, or if they had been diagnosed as living with dementia or a learning disability.
- The trust target for the completion of discharge summaries within 24 hours was 77% on weekdays and 60% at weekends. Between April 2016 and February 2017, the trust did not reach weekday targets in any single month. Best performance was 68% in April 2016, with the poorest performance being in December 2016 at 56%. Weekend performance was also substantially below target in the same period. The highest achievement of this target was in June 2016 with 35%, with the poorest performance occurring in July 2016, with just 20% of discharge summaries completed within 24 hours of discharge. This meant patients were sometimes discharged without appropriate notes being available to their GP, with the risk of an adverse effect on their ongoing care. We did not see any plans for this to be addressed.
- Ward staff completed a health needs assessment and continuing care checklist for each patient who was discharged into a care home.
- Communication between medical staff in the hospital and GPs in the community was effective. We heard of examples of conversations held with GPs, particularly by acute physicians to design plans of care, and to plan for discharge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood the relevant consent and decision making requirements of the Mental Capacity Act 2005. We saw staff took time to support patients to understand their options and make informed choices about their care. We heard of an example where a patient had refused to give consent for treatment and staff had taken appropriate steps to ensure the patient's safety and to determine whether the patient had capacity to make this decision.
- Where there was a question over the capacity of a patient to consent, we saw that time was taken ensure an assessment of capacity could take place, and this was recorded clearly.
- Staff were able to describe the differences between lawful and unlawful restraint, including the appropriate process for seeking authorisation of a deprivation of liberty. We did not see any examples of this during our inspection.
- We saw that where patients had a do not resuscitate decision in place, their capacity was clearly recorded on the documentation.

Are medical care services caring?

Good

We rated caring as good because:

- Feedback from patients and relatives was consistently positive.

Medical care (including older people's care)

- Patients said staff were caring and compassionate, treated them with dignity and respect, and as an individual.
- Staff were skilled to be able to communicate well with patients and keep them informed of what was happening and involved in their care.
- Relatives and carers were encouraged to be involved in care as much as they wanted to be.
- We observed staff treating patients with kindness and warmth.
- Staff had knowledge of patient circumstances and the impact their health had on them and their families.

However:

- A small number of patients reported nurses did not always respond in a timely manner when they rang call bells.

Compassionate care

- Staff understood and respected the personal and religious needs of patients and took these into account. A patient we spoke with reported that staff respected their need to pray before treatment was undertaken and ensured they were given the time to do this.
- We spoke with 27 patients, families and carers across the medicine division and nearly all were overwhelmingly positive about the care and treatment they had received. Patients told us they had received compassionate and sensitive treatment and care by staff.
- Staff took the time to interact with patients and those close to them. Patients and relatives we spoke with said that staff members ensured they were informed of what was happening and why. However, a small number of patients reported how staff were very busy so sometimes didn't respond very quickly to call bells. During our time spent on Simpson ward we observed that call bells were not always answered quickly.
- Staff understood the importance of ensuring patients knew who they were and what their role was. We observed staff introducing themselves and patients we spoke with reported they knew who was involved in their care, why and their role.
- Staff ensured patients' privacy and dignity was respected. Curtains were drawn when patients were receiving care or treatment and when consultations were taking place. Staff ensured sensitive conversations were held in a way so that other patients and relatives could not overhear.
- Care was given in a caring and unhurried way. We observed a staff member supporting a patient to the bathroom. This was done in a way to ensure the patient felt supported and unrushed. One patient told us "Doctors and nurses spend as much time with you as you need".
- Most patients we met spoke highly of the service they received. Feedback we received from the patients was very positive about the care they received. The comments we received during our discussions with patients included "care could not have been better", "everything has been wonderful", "staff are so helpful, nothing is too much trouble, "I have been treated like royalty", and "I love this hospital, there is no second choice".
- However, some patients reported that staff did not always provide them with the time or care they required. One patient informed us, "some of the nurses, not all of them, just walk past" another patient reported, "nurses take a long time to answer call bells and some nurses take the time and others don't".
- When patients experienced pain or discomfort staff responded in a timely and appropriate way. All patients we spoke with reported their pain was assessed regularly and appropriate pain relief was given. We observed pain assessments being undertaken.
- An active body of volunteers worked across the hospital, including buddies on medical inpatient wards. Volunteers spent time with patients and their visitors, providing practical support during challenging times.
- The Friends and Family test results for medicine at between February 2016 and January 2017 had a response rate of 10%, which was worse than the England average of 25%. The percentage of patients who would recommend the service was consistently above 90%.

Understanding and involvement of patients and those close to them

- The patients we spoke with told us staff were respectful of personal choices regarding treatment and care.

Patients said they felt staff listened to their concerns and were given time to discuss and explore these. One patient told us "Staff are very personal and friendly; they treat you as an individual".

- Staff ensured patients understood their care and treatment. Patients told us doctors explained what treatment needed to be carried out. They reported this was done in a way in which they could understand and enough information was provided for them to make informed decisions.
- Staff were skilled in talking to and caring for patients. We observed clinicians ensuring the patients understood what had been discussed and whether they had any questions.
- Staff understood the importance of involving the relatives and carers of patients where appropriate. We spoke with a patient and their carer who told us staff ensured the carer was allowed to visit beyond normal visiting hours and was involved in decision making and any discharge plan that was devised. This had helped with continuity of care and a smooth discharge.
- Discharge was arranged around the needs of patient. Patients we spoke with who were due to be discharged told us they had been kept informed of the discharge plan and that this had enabled family, relatives or carers to prepare and bring in any possessions needed.
- Staff recognised when patients needed additional support to help them understand and be involved in their care and treatment. For example we saw they were knowledgeable, compassionate and patient when dealing with a patient who had a hearing impairment.
- We saw that patients and their next of kin were actively engaged in their care and decisions made about them. During the daily multidisciplinary meeting, we heard repeated examples of plans to discuss options with patients and their families, with decisions delayed until these conversations had occurred. We observed patients being consulted about their options and given information and time to make informed decisions. Where patients were not able to make these decisions, for example because they did not have capacity to do so, we saw that their families or next of kin were consulted.
- We observed a thank you letter sent to the Chief Executive of the hospital relating to the care a patient had received. The letter praised the member of staff and ward for their empathy, compassion and treatment of both the patient and their family. Comments made included, "they truly engaged with me, my immediate family and extended family".

Emotional support

- One patient told us they felt staff had invested time to get to know them as an individual. This understanding was invaluable when they had become upset and concerned about their health and future.
- We observed emotional support provided to patients. Staff understood that emotional support extended to beyond a patient's medical condition. We observed a staff member providing emotional support to a patient who reported they had experienced a bad dream. The staff member spent time with the patient discussing the dream until they felt reassured and happier.
- Staff showed good awareness of the effect a patient's condition might have on their wellbeing and on those close to them, both emotionally and socially. Staff told us they felt they not only had a duty of care to the patients but also to their families. Patients and those close to them said "the compassion and care, both practical and emotional, demonstrated was phenomenal".
- We observed staff providing emotional support to patients and relatives during their visit to the department. Patients' individual concerns were promptly identified and responded to in a positive and reassuring way.
- Staff took measures to ensure patients could remain connected to life outside the hospital. For example, arrangements were made for patients who were end of life to have their pets visit them in hospital.
- Staff showed a supportive and sensitive attitude to patients. We observed staff taking the time to talk to patients who were distressed. One patient told us "A doctor sat with me for over 45 minutes when I was upset until I felt better".

Are medical care services responsive?

Good

We found the issues identified during our inspection in February 2016 that caused responsive to be rated as requires improvement had been addressed.

Medical care (including older people's care)

We rated responsive as good because:

- The number of discharges had increased at weekends due to improved senior medical cover.
- The division consistently met targets for senior review of acutely admitted patients, both in and out of hours.
- Staff working with specific patient groups were trained to be able to care for these patients in the most effective way to meet their individual needs.
- A twice daily multidisciplinary meeting steered patient care and ensured actions were completed to advance diagnosis and treatment in support of patient flow.
- The division worked closely with community based colleagues to ensure an efficient and safe step down process was in place for discharged patients.
- Emergency admission units were used effectively to admit and assess patients in a timely way, and worked effectively with the emergency department.
- Patients classed as outliers were managed effectively with regular reviews and appropriate care.
- When on the highest level of OPEL alert, we saw effective and efficient implementation of processes which allowed for patient safety to be maintained whilst addressing the critical capacities issues the trust was facing.
- There was a clearly structured process in place for the management of complaints, which we saw worked well to address concerns of patients and their families.

However:

- Day rooms on the care of the elderly wards were not being used by patients. On Simpson ward the day room was very unappealing and sparse.
- Patients with dementia were not always cared for in line with national guidance from the Alzheimer's society. Performance against the dementia FIND targets fell substantially below expected levels.

Service planning and delivery to meet the needs of local people

- Services were planned and delivered in a way that met the needs of local people. Staff demonstrated an understanding of the needs of the local population, a significant number of whom were elderly. Managers within the division talked of the challenge this presented and how the drive towards working with community colleagues went some way to mitigate the effects of this challenge. In addition, staff acknowledged the health needs of specific population groups in the local area. These included seasonal visitors, which increased the local population by up to 100,000 in the height of summer, and those with alcohol related illnesses. Staff also spoke of a greater level of deprivation in the local areas and the challenges this could present.
- A manager from within the local clinical commissioning group (CCG) had an active role within the leadership team of the medicine division to aid the development of strategy.
- An acute medical unit provided care to ambulatory patients who could be referred either by their GP or from another area of the hospital. The unit was open from nine o'clock in the morning until half past midnight. The last admission to the unit was at nine o'clock in the evening. This unit was staffed by nurses and doctors, with consultant support available from 2pm. This unit aimed to treat patients swiftly, without them having to visit the emergency department, and either be discharged or admitted as necessary.

Access and flow

- The trust had two emergency admissions units where patients who were being admitted to hospital generally went to first. The emergency admission units had a planned patient flow system, which began in the emergency department and ensured a clear pathway through the admissions process. An emergency department sister triaged patients and, where the decision was made to admit, patients were moved to the emergency admissions unit four (EAU4). Ambulatory cases were transferred to the acute medical unit. Those patients who did not meet the criteria for the ambulatory unit then went as medically expected patients to EAU3. There was a drive to make one of these units a short stay area that could be regularly cleared for new admissions. At the time of our inspection this was not happening due to capacity issues within the hospital and patients were routinely staying on the unit for more than 24 hours. The units were staffed by a number of doctors at varying levels of seniority who were able to assess patients quickly, order any tests that were needed and develop a treatment plan. When in use in the planned way this system impacted positively on access and flow within the hospital.

Medical care (including older people's care)

- All inpatient areas within the medicine division held a twice daily 'huddle'. This was a multidisciplinary meeting, attended by a dedicated discharge coordinator. Nursing staff told us this proved to be an effective mechanism for identifying patients who were medically fit for discharge. It also addressed any additional issues that may prevent a timely discharge. The time of this meeting had been changed to occur earlier in the morning, with the aim being to increase the numbers of patients who could be discharged before 11am.We were told this was working well, however we did not see any information which captured the actual benefits of the rearranged system.
- Following the huddle meeting a daily board round occurred which further built on plans discussed in the morning. We saw this enabled actions to be taken efficiently to diagnose and treat patients and help with improved flow through the hospital.
- In addition to the EAUs, the trust operated an acute medical unit (AMU). Access to this ambulatory unit was via a referral system. The ward clerk took initial information, and then passed this to a doctor for a decision to be made about whether attendance in the AMU was correct for the patient.
- The trust operated a drop-in TIA clinic between Monday and Friday. A transient ischaemic attack (TIA) or 'mini stroke' is caused by a temporary disruption in the blood supply to part of the brain. This had been set up as an efficient way for patients referred by their GP to access this service.
- At the time of our inspection the medicines division had six medical outliers. An outlier is a term to describe patients who may be receiving care in areas of the hospital with different specialties. There was a downward trend in the numbers of patients being cared for as medical outliers during the six months prior to our inspection. Between November 2016 and March 2017 the average percentage of time medical patients spent as outliers varied between 5.05% at its peak in November 2016, and 1.71% in March 2017. The medical outliers at the time of our visit were being cared for on two surgical wards. Medical patients outlying on surgical wards were looked after in two different ways. Two surgical wards were also base wards for gastroenterology. On these wards, the gastroenterology teams managed the medical outliers. On those surgical wards where there was no home medical team, an agreed medical team would take charge of those patients.
- Between December 2015 and November 2016 the average length of stay for medical elective patients at Torbay hospital was 4.9 days, which was higher than the England average of 4.1 days. For medical non-elective patients, the average length of stay was 4.5 days, which was lower than the England average of 6.7 days.
- Between February 2016 and January 2017 the trust's referral to treatment time (RTT) for admitted pathways for medicine was in line, or better than, the England average. For January 2017, data showed 95% of this group of patients were treated within 18 weeks, which was better than the England average of 89%.
- During our inspection the hospital had declared they were at 'OPEL four '. OPEL stands for operational pressures escalation level and describes the actions a trust is expected to take to manage capacity pressures. OPEL four is the most severe level. Two hourly meetings occurred during the day, which were attended by key members of senior staff from the hospital and community. They looked at how many patients were waiting for beds in the emergency department, planned discharges and patients who had a length of stay over 10 days. Each meeting updated senior staff on the position of each ward and the emergency department. Senior staff followed set criteria for OPEL four and action plans were put in place and updated at each meeting. Actions included the cancellation of planned training, the community intermediate care team looking to see if they could discharge any patients, and reviewing beds in community hospitals and care homes. Patients who had been in Torbay hospital for over 10 days were identified and these patients were all reviewed quickly and efficiently to see if any were able to be discharged. Staff on the wards also reviewed patients who were planned for discharge the following day to see if they could free up beds earlier in the morning by making sure everything they needed was in place to go home.
- The trust operated a medical admissions avoidance team. This team was led by a matron and could arrange scans and give results to patients to avoid the need to stay in hospital.
- Between April and November 2016 the medicines division were performing at or just better than the national target for patients waiting longer than six

weeks for diagnostic tests. This situation deteriorated between December 2016 and February 2017 when the trust performed worse than the national target of 1%, with December 2016 being the worst at 4.7%.

- The trust had a varying performance against target waits for cancer treatment in the 12 months preceding our inspection. March 2017 saw the trust exceed national targets for two week waits from referral, with 98% of patients seen in this timescale against a target of 93%. However, overall figures for the period April 2016 to March 2017 averaged at 89%. Further targets address the wait from the decision to provide treatment, to treatment beginning, which should occur within 31 days. The national target for this is 96%. The trust performed at or above (better than) this target each month in the year preceding our inspection. The trust also performed consistently at or above (better than) the 94% target for further treatment occurring within 31 days during the preceding year.
- Gastrointestinal consultants were involved in the on call rotas to cover weekends. Senior staff told us this had an impact on endoscopy lists and outpatients clinics as these consultants then needed to take time off in the week. They told us this equated to the loss of 60 endoscopy lists per year, and the fear was this would negatively affect waiting times. At the time of our inspection, the data for colonoscopy waiting times from April 2016 to March 2017 showed the vast majority of patients were waiting between one to five weeks. No patients were waiting over 13 weeks for any of these diagnostic tests.
- An 'alternatives to admission' document had been created which outlined clear actions to be taken in the medical specialities to treat patients without them needing to be admitted to the acute hospital.
- The trust had improved it's performance with relation to the number of patients transferred around the hospital after 10pm. Bed moves during these hours are undesirable due to the negative effects on patient wellbeing that can be associated with such transfers. We were provided with data which showed us the number of bed moves that occurred after 10pm and before 6am. This information showed that in April 2017, 9% of patient transfers occurred during these hours. However, this figure had been as high as 21% in March 2017.
- We saw examples of planning for discharge occurring early in a patient's stay. Estimated discharge dates were established upon admission. This involved identifying the actions that needed to have taken place prior to a patient being discharged, and this was followed up daily. This worked effectively and staff told us it helped "keep things moving" and ensured patients did not stay in hospital longer than needed. Patients who had been in hospital longer than ten days were given particular focus to identify mechanisms to discharge them safely. One of the main challenges faced by the medical wards was the discharge of patients with complex needs. There were a number of patients who were medically fit but required support or placements in care homes once they had left hospital, which took time to arrange.
- Performance in relation to delayed discharges was an improving situation at the trust. Delayed discharge describes a situation where a patient who is medically able to leave the hospital is prevented from doing so because of other restrictions, for example the lack of social care provisions. During the week of our inspection there were 28 delayed discharges. The average length of delay over the preceding six months was just over three days. The increased effectiveness of daily multidisciplinary meetings, and forward planning starting at the point of admission was credited for the improved performance.
- Senior leaders within the division told us how they had reconfigured cover of consultants over the weekend to include four specialties. This meant patients in hospital during this period could receive care from specialist consultants. It had also resulted in an increased number of patients being discharged at weekends, avoiding unnecessarily long stays.

Meeting people's individual needs

- Staff worked continually to meet the individual needs of people receiving care. Where necessary this was in modified ward environments.
- Care of patients with dementia generally represented good practice with a small number of exceptions. For example, the noise and clutter on care of the elderly wards was not conducive to the needs of a patient with dementia. However, the use of additional resources meant patients on care of the elderly wards had access to activities to reduce the risk of social isolation.
- Services were planned to take account of the needs of different people wherever possible. We did not see any

areas where male and female patients were cared for alongside each other, and side rooms were used where possible to accommodate the most suitable patients, for example those receiving end of life care.

- Although we did not observe them in use, we saw that arrangements could be made to support patients whose first language was not English.
- Rooms away from the bedded areas were available on wards for patients to spend time in, but these varied in quality and use. On Cheetham Hill the dayroom had been equipped with some objects to help with reminiscence, and a quiet area. We did not see this room being used by patients during our visit. It was, however, used for a multidisciplinary meeting twice a day. The day room on Simpson ward was uninviting, with hard tables and chairs and very little comfortable seating. We were told the dayroom was also used for a lunch club, where music was played and patients were invited to take part. There were some books and memory boxes available, but little other equipment that may invite a patient to spend time in there. This dayroom was also used for twice daily staff meetings. Again, we did not see the room being used by patients during our visit. On the George Earle stroke unit, the dayroom also had a pull-out bed which could be used by visitors if the need arose, and this provided reassurance to some patients that their families or carers could be close by if they wanted them.
- All staff who worked with patients with dementia had received training from dementia champions within their teams. Staff told us they felt confident in their knowledge of best practice, but sometimes workload made it difficult to respond quickly to patients' needs. For example, on Simpson ward we noticed call bells were left ringing a number of times during our time there. We observed a patient with dementia being told "I'll be with you in a second" repeatedly over a ten minute period, which increased the volume and frequency of their calls. The cluttered and busy environment of the care of the elderly wards were not conducive to the wellbeing of patients with dementia, and busy reception areas were noisy and situated right outside bays and side rooms on these wards.
- Staff on Cheetham Hill ward told us they were working with the lead nurse for dementia to make changes to their ward to improve the way they cared for patients with dementia. For example, they were encouraging the use of 'this is me' documents, which provided key information about patients who may not be able to express this information themselves. They were also looking to provide more items to aid with reminiscence, and finger food to encourage patients to eat. Training for staff, which included how to manage challenging behaviour and de-escalation techniques, was also underway. On care of the elderly wards, volunteers with an understanding of the needs of elderly patients provided assistance with activities.
- Patients with dementia were not always cared for in line with national guidance from the Alzheimer's society. Performance against the dementia FIND targets fell substantially below expected levels. FIND targets describe the national requirement to find, assess and refer 90% of patients with dementia within 72 hours of admission. Between April 2016 and March 2017, the worst performance was in June 2016 with just 23.5% of patients being referred in this timescale. The best performance was in February 2017, with 62.9% of patients being referred.
- Other improvements were on going for patients living with dementia. These included better signage around the wards and the use of night time diaries to monitor and review night time activity. Additionally, medicines for the management of symptoms associated with sundown syndrome were being used. Sundown syndrome is a neurological phenomenon associated with increased confusion and restlessness at dusk. Relatives and carers were able to stay the night if required to support their relative. Patients admitted with dementia were reviewed by medical consultants for care of the elderly and had mental health input from a psychiatric team from a local mental health provider.
- The trust had a psychiatric liaison service, which consisted of a consultant psychiatrist and nurse practitioners. This service provided support to medical patients and staff providing their care. Patients could receive a mental health assessment if required and the team were able to suggest care plans. If advised by the mental health team, a specialist mental health nurse could be provided to care for patients with particular risks who were unable to be transferred to an appropriate bed.
- Patients told us they were happy with the visiting hours for relatives and said staff had been flexible with these to accommodate visitors who could not visit during the set period.

- Patients living with a learning disability had a learning disability passport completed. This contained information on their personal likes and dislikes as well as their medical history and contact details of those involved in their care. The trust also employed a learning disability liaison nurse who could be called upon to offer support in the care of patients with a learning disability.
- The acute side of the trust was working closely with community-based colleagues to ensure the smooth and safe discharge of patients with complex needs who may require additional support when leaving hospital. This included the use of peripheral community based hospitals, and integrated care providers used as a 'step down' from acute care. We saw this worked extremely effectively in discharging patients from acute hospital beds in a safe manner.

Learning from complaints and concerns

- The trust had a robust and clearly structured process in place for the management of complaints. The associate director of nursing together with an administrator assigned a lead investigator to each complaint based on its content. The investigation lead would normally be the matron and ward manager responsible for the area in question. The clinical director was included routinely in the outcome of each investigation, which a member of the complaints team would discuss at each monthly divisional meeting.
- In the year prior to our inspection, the medical services division received 141 written complaints. We looked at three examples of complaints received and how they were managed from receipt until resolution. All were acknowledged and allocated for investigation within designated timescales. Two were not concluded within the allocated timescales but where this was the case, letters were sent to explain this to the patient.
- The complaints team had access to information about the incidents submitted by staff, and were able to identify areas likely to generate a complaint. Complaint investigations and outcomes were discussed and shared with matrons during weekly governance meetings.
- We saw people who submitted complaints were invited to the hospital to meet with appropriate staff to discuss the issues raised. This was used as a tool to personalise a response that would otherwise be completed by letter.
- Matrons had received complaints management training and were able to offer this to other nurses based on identified needs.
- Patients told us they would feel confident to make a complaint if they needed to. We saw posters that gave patients information about how to make a complaint.
- Nurses working on the wards told us that where learning was taken from complaints this was shared with them in regular team meetings.

Are medical care services well-led?

Good

We found the issues identified during our inspection in February 2016 that caused well-led to be rated as requires improvement had been addressed.

We rated well-led as good because:

- There was a clear strategy which addressed the key pressures within the medicine division.
- There was a focus on ensuring key messages from the governance team reached front line staff, and staff had a broad understanding of the direction of the medicine division.
- Staff felt connected to their line managers, able to raise concerns and make suggestions.
- A supportive and open culture was evident throughout the areas we visited.
- Risks were identified reviewed regularly. Actions to lessen the impact of these risks was taken swiftly and communicated clearly.

However:

- Friends and family response rates were generally poor.
- Divisional leaders were not clearly visible to staff working in the medicine division.
- Staff felt poorly informed about the plans for acute bed closures and this caused anxiety and uncertainty in many staff we spoke with.

Vision and strategy for this service

- The medicine division had a clear strategy that outlined the direction of improvements within the directorate. It aimed to support people as close to home as possible, reducing reliance on bed-based care and strengthening capacity and capability within the community to

achieve this. Senior staff within the medicine division had developed a strategy which focused on an investment in community services to result in an improved flow through bed-based care in the hospital. A number of initiatives were being started that aimed to assess patients more rapidly and shorten their length of stay, by providing facilities in the community that could meet patient needs.

- We spoke with the leadership team for the medicine division about the challenge of managing capacity and flow through the service. We were told this had greatly improved since the implementation of the division's strategy, although it still proved to be a great challenge to the trust.
- We saw practices that were in line with the strategy, such as a twice-daily multidisciplinary meeting on each ward that identified whether patients were medically fit for discharge and what actions could be taken to support them into community-based health provision when it was necessary.
- Progress against the delivery of the strategy was regularly reviewed and discussed during monthly directorate governance meetings, which were attended by leaders from specialties within medicine.
- Front line staff told us they had a broad understanding of the vision and strategy, although were not able to describe the strategy in detail.

Leadership of service

- Leaders had the skills, knowledge and experience needed to be effective in their roles. Many leaders of services we met had previously worked within the trust in more junior roles. They told us they felt this helped them in their current leadership roles as they had a greater understanding both of the trust as a whole, but also of the challenges their teams faced.
- A recent "'call to action' had meant that for a period of three months between January and March 2017, ward-based leaders had not been able to use supernumerary time to complete management tasks. This time was instead used to deliver clinical care to improve efficiencies on the wards. The effect of this was that management tasks had to be completed in clinical time. Leaders told us this had proved difficult but they were supported by staff and managers, and high priority tasks, such as rota management and annual leave coordination, were completed.
- Staff told us they were encouraged to make suggestions on the development of the service and that an open and honest relationship with their line manager encouraged this. Front line staff told us their direct line managers were approachable and were very aware of the challenges they faced on a daily basis.
- Staff were aware of the whistleblowing policy and were confident in its use. At all levels within the medicine division staff were able to explain the principles of whistleblowing. Staff said they felt the trust promoted the whistleblowing policy openly. Of the staff we spoke with, none had ever used the policy to raise concerns.
- Local leaders were visible to staff. All staff we spoke with felt connected with their immediate line management team. However, staff also said divisional leaders were not as visible. Initiatives were in place that ensured staff at all levels were kept informed of developments across the division and the trust by means of a monthly newsletter. Ward leaders were responsible for writing and circulating a newsletter that contained information and updates significant to staff.
- A ward manager told us the trust seemed to be "much more joined up now", with lessons learned from mistakes. They said communication had improved and staff were kept better informed of changes.
- Newly qualified nursing staff were assigned a buddy who, with the support of leaders, acted as a mentor through their preceptorship. Nurses told us this worked well and had been an invaluable source of support when they were starting their nursing careers.
- Meetings at ward manager level and amongst matrons allowed for concerns and issues from individual areas to be discussed. These were then fed up to the next level of management and staff felt they got a response from their concerns or issues using this system.

Governance, risk management and quality measurement

- There was a clear and effective governance framework that supported the delivery of the strategy and safe, good quality care. Focus had been given to the relationship from 'ward to board'. The divisional general manager led the medicine division's monthly governance meetings, supported by the associate director of nursing. The clinical directors and managers within the specialties covered by the medicines division also joined these meetings. Monthly governance meetings were held to discuss incidents, accidents and

risks. The standing agenda items for the meeting aimed to ensure all areas involving risk and quality measurement were discussed. This agenda was duplicated for meetings at different levels of leadership with the aim to ensure conversations about the same areas took place and were fed up and down the lines of management.

- Staff told us they were clear about their roles and responsibilities. At differing levels staff were able to tell us how they carried out their role safely and what they would do if they encountered problems. Staff were clear about who they should report various types of adverse events to and how these reporting mechanisms worked.
- There were arrangements in place to identify record and manage risks. The divisional risk register incorporated information about the risks identified, how they were being managed and any mitigating actions that were in place to reduce the impact of these risks. The top risks identified in the divisional risk register were waiting times for dermatology and endoscopy, ward staffing levels and neurology consultant capacity. For these risks, mitigations involved business planning to increase resources, reorganisation to create efficiencies and action planning to target improvements. This resulted in a reduction of risk scores to a more acceptable level. Risks were reviewed monthly by the medicine division governance team and reassessed.
- The medicine division used a quality improvement dashboard to monitor the quality of service being delivered to patients. This provided information at a glance, which enabled managers to assess issues and identify improvements.
- The tissue viability service told us they were involved in meetings with the governance team about pressure ulcers and the management of these. These meetings reviewed the numbers and grades of pressure ulcers reported, with the aim of having clearer information about the prevalence of these within the trust.

Culture within the service

- Staff told us they felt respected and valued in their roles. Although busy, they said they felt their efforts were recognised and the workload was beyond the control of their line managers. All staff we spoke with, regardless of their role, spoke positively about the working culture of the hospital.
- Junior staff told us they were encouraged to develop and learn new skills within their role. In turn, they felt the extra benefits they were able to bring supported the work of their team. Registered nurses told us that a move to employ more band four unregistered nurses and train them had led to an improved ability to manage their workload. Band four nurses, although unregistered, were able to carry out a number of tasks previously only undertaken by qualified nurses, once they had been trained and had their competencies assessed.
- We observed a culture that was based on the needs of the people using services. Without exception, all of the wards and areas we visited had worked hard to meet the needs of their patients. On Cheetham Hill, a care of the elderly ward, we saw care had been taken to make the dayroom inviting to patients with dementia. Food and snacks were available to patients outside of fixed mealtimes to encourage those with poor appetites to eat when they wanted to. On the twice daily multidisciplinary meeting we saw patients discussed with compassion and treated holistically, and this was embedded in the approach.
- We were told of a culture of safety, openness and honesty in all of the areas we visited. Staff told us they were actively encouraged to speak up when they had concerns, and felt able to do so. One staff member described the support they had received following a drug error. They said the support had made a huge difference to their ability to cope with the situation.
- We saw shift leaders ensuring staff took breaks during our visit. Staff looked after each other's patients, ensuring they could take breaks without being disturbed, and looked after each other's wellbeing routinely during our time at the hospital.
- The trust had an awards programme and awarded staff and wards for performance in key areas. On wards where these had been won, staff were keen to share this with us, and were proud of their achievements. We were shown the certificate given to the complex discharge team where they had won 'gold' for their outstanding contribution to health and social care in Torbay and South Devon.

Public engagement

- The medicine division collected NHS Friends and Family Test data from each ward and used feedback to make improvements. However, response rates were relatively low at 10% against a national average of 25%.

- On Cheetham Hill ward, a care of the elderly ward, a quiet sitting room had been provided following feedback from relatives about the noise and busyness on the ward. This aimed to give families somewhere quiet to sit, which was seen as especially helpful during difficult situations.
- The trust employed carers' leads. These leads undertook surveys of the experiences of carers regarding their care in the trust. Feedback from these surveys demonstrated a positive picture of the way in which carers were involved and their input valued during the care of patients.

Staff engagement

- Staff were encouraged to give their views about their wards and the wider hospital. All the medical wards had staff meetings to which all staff were invited and encouraged to give their views about the ward and hospital. These were led by ward managers and we were told key messages were also passed to staff during these meetings, and key issues could be discussed.
- Staff did not always feel fully engaged with changes at the hospital. The trust was in the process of closing beds at the time of our inspection, the most recent having been a gynaecology ward. Staff told us consultation with them had been poor and many staff were surprised when the closure was announced. We spoke with staff who told us this had led to a feeling of uncertainty about their future, and staff did not feel senior managers were completely transparent about plans for further closures. Staff said they felt they were "told" rather than consulted with about such changes. Board papers demonstrated hospital leaders had identified their management of acute bed closures could have been improved. We did not see any actions that addressed this at the time of our inspection.

Innovation, improvement and sustainability

- To develop and improve senior medical cover out of hours, the division had reconfigured the working arrangements of consultants. This meant during the weekend patients had access to one of four consultants covering four specialities. This had resulted in greatly improved numbers of discharges and improved patient flow at weekends. It also provided greater support for junior doctors at weekends. However, this had an effect on the availability of consultants specialising in gastroenterology during the week. The outcome of this was a reduced number of lists available for endoscopy procedures.
- All of the inpatient areas we visited operated a twice daily multidisciplinary 'SAFER huddle'. The SAFER bundle blended five elements of best practice. When followed consistently, length of stay reduced and patient flow and safety improved. This twice daily opportunity to work collaboratively across roles had a positive effect on patient flow through the medicine directorate. Staff in all roles, and at all levels, talked of the benefits of this approach, which had been in practice for three months. We saw evidence that the benefits of this system were regularly reviewed and appropriate amendments made to improve the system.
- Leaders told us of a number of improvement plans across the medicines division. These included the appointment of an acute Parkinson's disease specialist nurse to provide advice and support around disease management whilst in hospital. Additionally, a consultant with a movement disorder interest had been appointed and was helping to provide a regular presence in the hospital for advice and support for patients with Parkinson's disease. Patients were placed together on a named ward with a weekly dedicated ward round involving a consultant specialising in Parkinson's disease and the specialist nurse, enabling patients to receive the most appropriate specialist care and to develop relevant nursing skills within the ward nursing team.
- The introduction of a 'direct to test' process within gastroenterology for people with suspected cancer had resulted in a reduction in outpatient attendances and a more streamlined service for patients.
- Development of the integrated heart failure team had seen improved and streamlined services for patients with improved outcomes. This had been achieved through the targeted recruitment of consultants and heart failure specialist nurses who provided support to patients and staff. The development of IT systems had also allowed cardiac patients to be tracked and identified when they were in hospital. This sped up the rate at which the management of their conditions was managed by the dedicated cardiology team.

Outstanding practice and areas for improvement

Outstanding practice

- The trust had fully addressed the requirement notices from our inspection in February 2016. In particular we saw significant improvements had been made in the emergency department in terms of safety, quality, performance and patient experience. The department had streamlined processes and introduced a system of triage and rapid assessment, which improved safety, efficiency and patient flow.
- We saw exceptional multidisciplinary working between the whole healthcare systemin response to the trust's escalation process
- A newly created mental health assessment room provided a safe, welcoming and calming environment, located away from the hustle and bustle of the busy emergency department.
- There was a separate children's area in the emergency department, which was secure and was not overlooked by adult patients and visitors. This area was staffed by a dedicated trained paediatric nurse workforce. In addition, adult trained nurses received paediatric training as part of their induction and mandatory training.
- There were cooperative and supportive relationships amongst staff in the emergency department. We observed excellent teamwork, particularly when the department was under pressure.
- Service improvement was everybody's responsibility in the emergency department. Staff had been engaged in the improvement journey and had been encouraged to participate in service design and to make suggestions for improvement.
- There was a great sense of pride amongst staff in the emergency department. They contrasted their feelings of despondency at the time of our previous inspection, with feelings of pride and optimism in the present.

Areas for improvement

Action the hospital MUST take to improve

- Ensure the secure storage of confidential patient records in all areas.
- Ensure all medical equipment in the emergency department is serviced in accordance with service schedules.

Action the hospital SHOULD take to improve

- Ensure signatures on nursing, medical and prescription records are legible.
- Ensure risk assessments are consistently completed.
- Ensure resuscitation trolleys and emergency equipment are checked daily across all medical areas in line with trust policies.
- Ensure systems aimed at ensuring the safety of medicines are effective, for example the checking of refrigerator temperatures and expiry dates.
- Consider how staff can be better included in consultation processes where service changes may affect them.
- Ensure mandatory training targets, including adult and child safeguarding, are consistently met.
- Ensure fire escape routes are kept free from clutter and obstructions.
- Ensure all staff comply with minimum training attainment levels.
- Ensure appraisals for nurses are completed.
- Ensure that regular mortality and morbidity meetings take place and related issues are included in emergency department clinical governance meetings.
- Ensure that appropriate and regular audit takes place.
- Ensure staff to patient ratios in the emergency department are appropriate to keep patients safe at all times.
- Ensure children waiting in the main waiting room of the emergency department are provided adequate privacy away from waiting adults.
- Ensure resuscitation trollies and equipment in the emergency department are readily available and kept clean.
- Ensure the emergency department sluice is secured and that flammable products are not accessible to unauthorised persons.

Outstanding practice and areas for improvement

- Ensure Patient Group Directions used in the emergency department are signed by staff and counter-signed by managers.
- Provide training for emergency department receptionists to support the recognition of red flag presentations.
- Ensure access to major incident equipment in the emergency department is not obstructed.
- Ensure the bereavement (viewing) room in the emergency department Is an appropriate environment.
- Review the location and visibility of surgical waste bins that are visible from the emergency department relatives' room.
- Review the steps to support people in vulnerable circumstances, such as people living with dementia, or people with a learning disability are adequate.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **(1) Care and treatment must be provided in a safe way for service users.** **(2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include—** **(e) ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way;** An inventory and service history provided to us by the trust showed there was a significant amount of equipment which had no records of service or where service was overdue. Items included digital thermometers, blood glucometers, nurse call system, bariatric patient hoist, patient monitors, pulse oximeters, portable suction units, patient ventilators, a height-adjustable couch, and ECG recorders

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements of this Part.** **(2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to—**

This section is primarily information for the provider

Requirement notices

(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

Confidential patient records were not kept securely; records were stored on open shelves in the ward areas.